GUIDEBOOK

ON GERIATRIC PROGRAM DEVELOPMENT

IN COMMUNITY AND MIGRANT HEALTH CENTERS

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration

GUIDEBOOK

ON GERIATRIC PROGRAM DEVELOPMENT

IN COMMUNITY AND MIGRANT HEALTH CENTERS

July, 1990

Contract No. 240-88-0058

Authors:
Susan Koch Madden and Paul Campbell

Project Officer:
Elizabeth A. Hickey

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Bureau of Health Care Delivery and Assistance

DHHS Publication No. HRS-D-PC 91-2

Table of Contents

I. INTRODUCTION

A. HISTORY AND PURPOSE OF THIS GUIDEBOOK

This document is the product of collaboration between the Health Resources and Services Administration (HRSA) and the Administration on Aging (AoA), both agencies within the Department of Health and Human Services. Staff from both programs share the same goal of improving the health status of elderly Americans.

For myriad reasons HRSA-funded community and migrant health centers (C/MHCs) have not focused care, proportionately, upon the elderly. Persons over the age of sixty-five constitute approximately thirteen percent of the total U.S. population, and they consume an even greater share of health resources[1]. For that reason **twenty to thirty percent** of an average medical group practice's revenues during 1988 were provided by Medicare[2]. C/MHCs, however, do not exhibit the same trend. During the same year (1988), only **three percent** of an average urban health center's total costs, and **five percent** of an average rural health center's total costs, were covered by Medicare reimbursement. Proportionately, fewer elderly are served.

AoA officials wish to improve upon the health services available to many elderly who have not found Medicare to be the total solution to their access problems. Many cannot complete Medicare paperwork, afford increasing co-payments, deductibles or balance billings, or find physicians willing to accept assignment. Others find quality medical care available when relatively well, but more elusive when attention is most needed, when chronically ill and confined at home or in homes for the aged or nursing homes. Medicare Catastrophic Insurance addressed some of the financial worries of the poor elderly, but was subsequently repealed due to pressure from their wealthier contemporaries who were forced to pay for the expanded coverage.

HRSA officials are determined to address the health care needs of all medically underserved segments of American society, including the elderly. Their determination, like that of their counterparts in the AoA, is constrained by budgetary limits which seem to loom larger each day in this era of skyrocketing Federal deficits and competing demands for the same limited tax dollars. The elderly, however, unlike the many traditional C/MHC patients, (uninsured young women and children), do have considerable insurance coverage through Medicare, less than optimal as it is. For that reason persons over sixty-five years of age receiving less than adequate medical care are a

---

[1] Brody, Stanley J., and Persily, Nancy A.; Hospitals and the Aged; Aspen Publications; Rockville, Maryland, 1984.

[2] Medical Group Management Association; 1989 Cost and Production Survey Report; Denver, Colorado, 1989.

reasonable high priority target for C/MHC development efforts. Access can be expanded for this particular group without the need for substantial additional subsidy dollars through HRSA.

This guidebook exists to assist C/MHC staff and/or volunteers who wish to enhance services to the elderly. Not everyone will find the same information useful. The authors encourage readers to examine the table of contents, to review the following brief descriptions of the chapters, and to skim through the pages that lie ahead before deciding which portions are appropriate for close reading.

B. THE CONTENTS

This guidebook is further divided into six chapters, as follows:

The Geriatric Imperative. This chapter briefly presents information on the "graying of America", and expected consequences for medical services. Competition for the care of the aged is discussed. Unlike bad debt and free care patients, the elderly often do have options of varying quality to meet their medical needs. This chapter discusses the bases for that competition.

Geriatric Program Development. For many C/MHCs a decision to enhance services to the elderly may mean a reappraisal of which particular services are provided, as well as the manner of that provision. This chapter discusses services particularly important to the elderly, based upon current case research in C/MHCs, as well as information available in current literature.

Successful Health Center/Administration on Aging Coordination Efforts. C/MHCs interested in expanding their geriatric services may very well have considerable resources to tap, and without additional expense. The AoA has an extensive national network of state and regional planning organizations, as well as local service providers. These diverse organizations can assist in state advocacy efforts, provide elderly referrals, and even provide transportation to and from health centers, to name a few common linkages. This chapter provides concrete successful examples of health center and aging program synergistic efforts.

Medicare Reimbursement. Medicare reimbursement for physician services in general, and in C/MHCs in particular, is a complex and therefore challenging funding system to understand. Health centers have several Medicare reimbursement options unlike non-C/MHC providers. These options provide a potentially lucrative financial advantage over other types of providers, but add to the complexity of the reimbursement issues facing C/MHCs. And yet there is no one authoritative source providing the necessary information to assess the "best" reimbursement option to pursue. In addition, multiple agencies and companies are involved to different degrees, including the Health Care Financing Administration (HCFA), state health departments, HRSA and myriad fiscal intermediaries (insurance companies). This guidebook attempts to describe the Medicare reimbursement system and its options for C/MHCs. It offers general suggestions intended to enhance reimbursement, but stops short of providing the kind of detailed instructions to be expected in a more

narrowly focused cost report manual. Helpful appendices, such as cost report forms, are included.

Bibliography. This guidebook can only offer a starting point for those considering the development of geriatric services. As many questions will be raised as answered. A list of additional resources for those interested in pursuing the topics is presented.

Health Center Case Studies. Some individual health centers have been serving, proportionately, many more elderly than their C/MHC counterparts. Project researchers visited three such health centers, operating in both urban and rural settings, to find out why they served more elderly patients, and how they were providing care. These case studies found both differences and similarities among the sites visited, in Mound City, Missouri; Chattanooga, Tennessee; and Albany, Georgia. All three Medicare reimbursement modes were examined. Readers should learn from the histories presented, and are encouraged to contact the sites to gain any necessary additional information.

II. THE GERIATRIC IMPERATIVE

A. DEMOGRAPHIC TRENDS

The U.S. population is aging. In 1950 there were 12.4 million persons over age sixty-five, by 1980 there were 25.5 million, and in 1990 there are an estimated 31.8 million men and women over sixty-five. The elderly are also quickly gaining as a percentage of the total population. While they constituted approximately eleven percent of total U.S. citizens in 1982, by 1990 they are nearly an estimated thirteen percent of the total. This trend will continue, with still more radical shifts as the "baby boom" cohort ages. According to projections made by the U.S. Bureau of the Census, prior to the year 2025 the United States will have the same proportion of older people as Florida does today.

The over sixty-five population is not a homogenous group. There are multiple subgroups critical to planners and providers of health services defined according to income, race, sex, and of course, age. The following table, provided by the Bureau of the Census, displays important features about the general aging trend:

DISTRIBUTION OF THE ELDERLY POPULATION; BY AGE, 1980-2000

(Numbers in Millions)[1]

	1980		1990		2000	
Age	Number	Percent	Number	Percent	Number	Percent
All, 65+	25.5	100.0%	31.8	100.0%	35.0	100.0%
65 - 69	8.8	34.4	10.0	31.5	9.1	26.0
70 - 74	6.8	26.6	8.0	25.3	8.6	24.5
75 - 79	4.8	18.8	6.2	19.6	7.2	20.7
80 - 84	2.9	11.5	4.0	12.8	4.6	14.2
All, 85+	2.2	8.8	3.5	10.9	5.1	14.7

[1] U.S. Department of Commerce, Bureau of the Census, 1980 Census and Middle Series Estimates. Projection of the Population of the United States, 1982-2050. Current Population Reports, Series P-25, no. 922; U.S. Government Printing Office; Washington, D.C., 1982.

The above table reveals the large growth rates, in the very near term, of the so-called "fragile elderly". While the total population over age sixty-five is expected to grow approximately ten percent from 1990 to 2000, the group over age eighty-five is projected to grow by about forty-five percent. These statistics show how categories within the total aged group are changing relative to each other. Examined another way, by the year 2000 forty-five percent of those over sixty-five will be aged seventy-five or older, versus thirty-nine percent as recently as 1982.

Increased consumption of health services among the elderly stems largely from growth in the population over seventy-five years of age. Chronic diseases become prevalent at that stage in life, forcing individuals to demand increasing amounts of medical care. The relative elimination in the U.S. of communicable diseases has extended the period persons live with chronic conditions, radically increasing their need for services.

Added to epidemiological trends, and as influential in increasing consumption, are improvements in medical technology. A great deal of expensive diagnostic and treatment technology routinely administered today was not available in 1965 when Medicare was enacted.

A third factor affecting demand is the insurance coverage provided by Medicare and supplemental policies. All persons, including the elderly, purchase more care when they are relatively insulated from the economic impact of their purchasing decisions.

A final and positive demand factor relative to C/MHCs is the shifting locus of health services. Due to changing technology, and especially third party payer incentives and constraints, considerable demand has shifted from inpatient to outpatient services. Hospitals have responded strategically with outpatient medical and surgery centers, and private physicians are now routinely doing in their own offices what used to be limited to acute care settings.

B. COMPETITION FOR ELDERLY PATIENTS

Largely due to Medicare, the elderly often, but not always, have alternatives for medical care. Competition for Medicare insured patients, relatively greater in urban areas with higher per capita physician ratios, means that not all providers, including C/MHCs, will share equally in the elderly's increased demand for health services. Discussed below are numerous apparent bases for competition among medical providers, and their relevance for C/MHCs:

- o Cost
- o Staff
- o Facilities
- o Referral Channels
- o Continuity of Care

Cost. The elderly, a disproportionately low income portion of the population, are often extremely price sensitive. Even with Part A and B Medicare coverage, they face substantial out-of-pocket expenditures for health

services and are likely to alter utilization accordingly. Recently, due the increased cost and consumption of health services, the elderly's real (inflation-adjusted) average cost burden for health care surpassed the level existing in 1965 before Medicare enactment.

The elderly face the costs of an annual deductible ($75) as well as co-payments (20% of allowable charge) for physician's services. They face, in every state but Massachusetts, the need to pay charges beyond those allowed by Medicare, or the challenge of finding a physician willing to accept assignment. Those "excess charges" can be extremely high following an intensive episode of illness.

C/MHCs are in an excellent position to compete on this basis. All health centers accept assignment and, furthermore, apply sliding fee scale adjustments to co-payments and deductibles. In addition, they offer other services through adjusted fees that usually present cost barriers to the aged, including dental, pharmacy, radiology and laboratory services. The ability to purchase drugs at a reduced cost is a major incentive for chronically ill elderly, who are commonly on multiple medications.

A related advantage is reduced paperwork. Taking Medicare assignment means that health center staff remove the burden of claims preparation from the aged. This factor reportedly brought many elderly to one of the health centers studied in this project, especially those low income persons who never learned how to read.

Staff. Most elderly perceive their choice among providers as among individuals rather than among organizations. They are often characterized by long term relationships with their primary physicians, and are highly resistant to any disruption in this continuity.

Provider staff continuity has not been a strong feature of C/MHCs. Provider, especially physician, retention appears to be markedly better at health centers with substantial numbers of elderly persons. Doctors, however, are not the only key. Elderly patients have been shown to adjust well to mid-level providers, and personal relations with support staff, nurses and front office staff are also important.

Facilities. Like most non-medically trained patients, the elderly are relatively unable to evaluate the technical competence of the professionals diagnosing and treating their ills. They can, however, tell if the physical plant and equipment appear to signal second class care. Many of the health centers with substantial numbers of elderly patients had facilities which could not be distinguished, visually, from private practices in the area.

Referral Channels. Because the elderly are more likely to be sick, and to require more intensive and complex treatment, referral channels are relatively more important factors in their choice of providers. Elderly patients almost always know where their physicians do their hospital care, as well as where they will go for specialty care and ancillary services not provided directly by the health center. The reputation and appearance of these services is of concern.

Continuity of Care. Again, because they are more likely to be ill the elderly are more likely to be aware of a provider's ability to provide continuity of care, and to include that factor in decision-making. The elderly want to have telephone access to someone they trust (preferably but not necessarily one individual), personal care in the event of an emergency, and follow-up through hospitalization, nursing facility and home care. This seemed to be a very strong feature in the health centers examined in this study.

C. THE ROLE OF COMMUNITY HEALTH CENTERS AS PROVIDERS OF GERIATRIC SERVICES

In addition to their ability to compete successfully for elderly patients based upon the factors discussed above, C/MHCs are by their very nature and organization well-suited to the demands of a geriatric practice. While many elderly will need specialist care at times, high quality primary care plays a critical role in the maintenance of health and prevention of disease for the elderly. C/MHCs are in an excellent position to offer the following services for elderly patients:

Comprehensive geriatric assessments, including assessment of medical, economic and psychosocial risk factors. Geriatric assessments were once considered to be properly conducted within a hospital. Increasingly, however, assessments are being done in primary care setting. In fact, one study concluded that "most older individuals requiring comprehensive assistance could be assessed appropriately in the ambulatory setting by a multi-disciplinary team."[2]

Comprehensive care. C/MHCs offer multiple provider disciplines (including medical, nursing, and social work) that can operate as a team to deliver comprehensive and coordinated care. Furthermore, caregivers can maintain contact with and care for the patient in other settings (home, nursing home, hospital, and by telephone).

Emphasis on health promotion and disease prevention. C/MHCs have traditionally been strong on preventive care and health promotion. This focus is particularly helpful in working with the elderly and can help to improve their understanding of their health needs, maintain or improve functional status, and delay or prevent the need for institutionalization.

---

[2] Williams, Mark E., and Williams, T. Franklin; Evaluation of Older Persons in the Ambulatory Setting; Journal of the American Geriatrics Society; January, 1986, Vol. 34, No. 1; p. 37.

III. GERIATRIC PROGRAM DEVELOPMENT

A. INTRODUCTION

In this section of the manual, we will present a detailed description of the issues that must be considered by a C/MHC contemplating developing or expanding the geriatric services component of its program. We will focus on the programmatic and administrative issues related to development of a geriatric program, rather than on the content of clinical care.

Included will be a review of the health needs and utilization patterns of the elderly, and a discussion of staffing, equipment and facility needs. In addition, the services that are particularly important to offer in order to successfully serve the elderly, including help with insurance, the provision of care in alternative sites (nursing homes, home visits, etc.), continuity of staff, etc., will be detailed. We will also discuss the barriers that exist that hinder a health center's ability to build a geriatric practice, and the possible impact on a health center's productivity of increasing the number of elderly patients.

B. HEALTH CARE NEEDS AND UTILIZATION PATTERNS OF ELDERLY PATIENTS

A health center designing a program to serve the elderly needs to be familiar with the common conditions and diseases from which the elderly suffer, as well as their health service utilization patterns.

As a group, the elderly utilize a disproportionate amount of health care. Based on estimates from the National Health Interview Survey (1972), the elderly average 6.1 visits per year to a physician, compared with 4.1 visits per year by adults aged 45 - 64. The rate of hospital use is also significantly higher: 355 discharges per 1000 for the over 65 age group vs. 168 per 1000 for the entire population (National Center for Health Statistics, 1983). In addition, when noninstitutionalized individuals were asked to assess their own health, 30% of those 65 and over believed themselves to be in fair or poor health, compared with only 11% for all ages.

The most common types of conditions and diseases suffered by the elderly (based on hospital discharge diagnoses) are diseases of the circulatory system (specifically heart disease), followed by diseases of the digestive system and cancer. The most rapidly growing reasons for hospitalization are endocrine, nutritional, and metabolic diseases (including diabetes) (National Health Interview Survey, National Center for Health Statistics, 1977 and 1982). In an earlier study of geriatric services in C/MHCs (La Jolla Report, 1987), the most common diagnoses among their elderly patients were hypertension, heart disease, diabetes, arthritis and degenerative joint disease, cancer, and chronic obstructive pulmonary disease. Urinary incontinence and mental disorders were also common.

Two of the three health centers visited for this project had collected data on the most common diagnoses for their over 65 patients. The most common diagnoses in these health centers were the following:

- o high blood pressure
- o heart disease
- o diabetes mellitus
- o degenerative joint disease (arthritis, etc.)
- o dementia
- o urinary tract infection

Although the majority of elderly persons are healthy, chronic conditions become increasingly prevalent with increasing age. In fact, nearly half of the office visits by the elderly are for routine care for chronic problems, about 25 percent for acute problems, and 12 percent for flare-up of chronic problem. This is an important factor for health centers worried about the impact of the elderly on their providers' productivity. The average duration of a visit for a previously seen patient is less than a visit for a new patient, and still less for treating a previous patient for an old problem in comparison to treating the same patient for a new problems. Only 10.2 percent of visits by the elderly were classified as "new patient" versus 15.8 percent for all ages combined.

C. STEPS IN DEVELOPMENT OF A GERIATRIC PROGRAM

The initial planning stage in the process of developing geriatric services consists of three tasks, discussed below.

1.) Community Needs/Demand Assessment. It is crucial for planning purposes to gather data on the demographics of the community with special emphasis on the elderly population. Included in this study should be data on the health status of the elderly and any health risks or problems, unmet needs, and available community resources (including competitors).

2.) Development of a Geriatric Health Care Plan. The plan should be based upon the findings of the needs/demand assessment and utilize the BHCDA Lifecycles as a guide and starting point. The plan should establish protocols and guidelines for routine and preventive care, as well as plans and activities aimed at specific problems or needs in the elderly community. Descriptions of the geriatric health care plans developed in the three health centers visited in this project are included in the case studies in Chapter VI of this manual.

3.) Training and Upgrading of Staff. Because many health centers will be using family practice physicians and mid-level practitioners (rather than geriatricians) to care for the elderly, specialized training in geriatric care is needed. Part of this training should focus on the development of a "team approach" to care, in which providers from various disciplines (medicine, nursing, social work, nutrition, etc.) work together to ensure that all of a patient's needs are met effectively and efficiently.

The training program should also focus on some of the unique aspects of caring for the elderly, including the following:

- Under-reporting of symptoms is common in the elderly;
- Multiple complaints are common, with depression occurring secondary to the myriad of problems faced by the individual;
- Normal laboratory values and the need for testing change with aging and special problems;
- Iatrogenesis is not uncommon. Many elderly are apprehensive about medical care, and especially the prescription of medications;
- Polypharmacy (i.e., taking many prescription medicines) among the elderly is a common problem.;
- Many individuals have difficulty understanding and dealing with health insurance forms and requirements;
- The importance of continuity of care increases, as does the need to provide care in alternative settings (home, nursing home, etc.); and
- Health promotion/education, and disease prevention activities are needed in order to lessen the likelihood of institutionalization.

Because of the complexity of the needs of many geriatric patients, two crucial cornerstones of good geriatric care are:

A complete geriatric assessment, including medical, social, economic, and psychological risk assessments; and

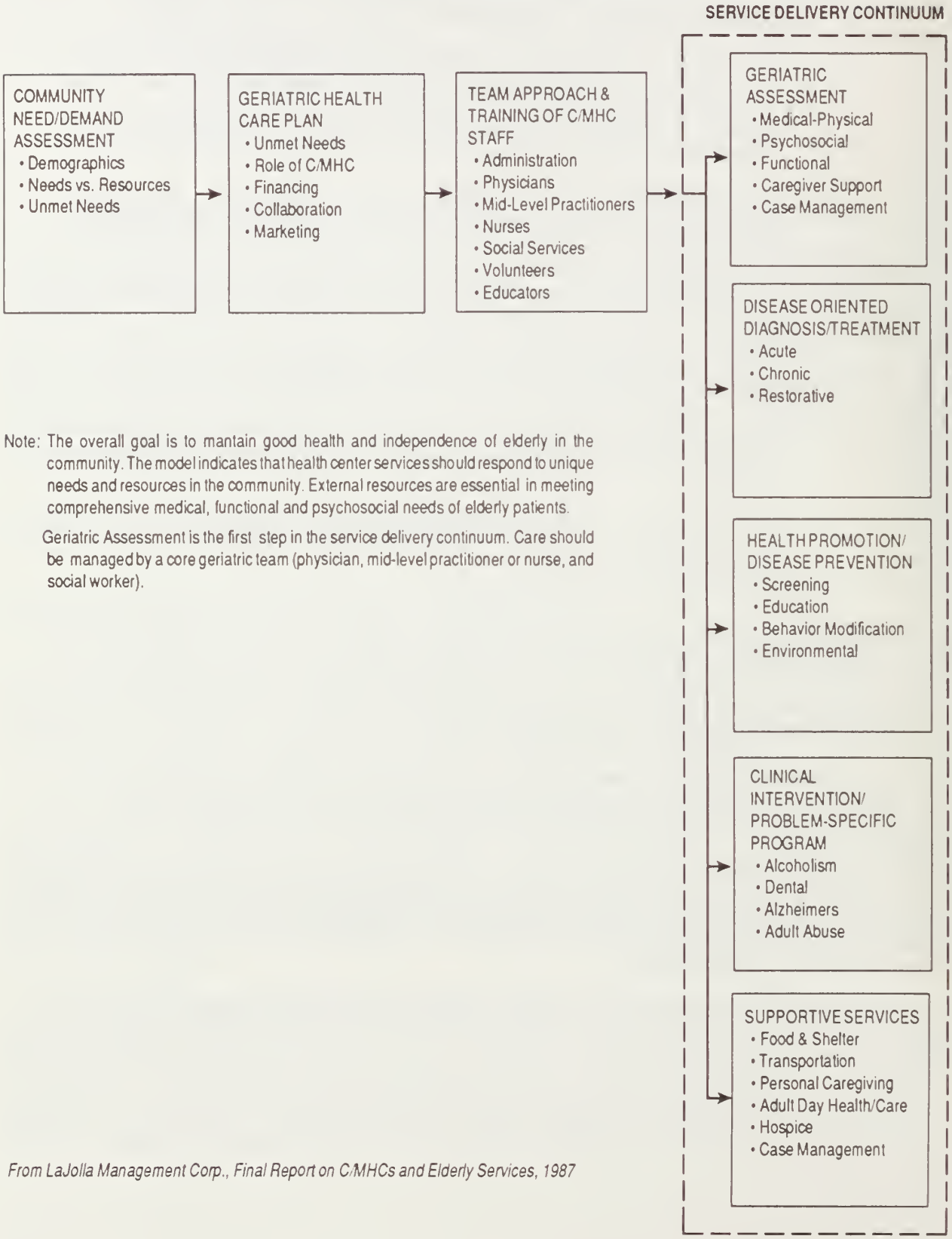
A multidisciplinary team approach, including a physician, mid-level practitioner or registered nurse, and social worker or individual with family and community knowledge and skills.

In addition, the role of the patient's family or primary caregiver can be more important for an elderly person, and greater emphasis needs to be placed on involving that person: encouraging their attendance at office visits, and ensuring that they understand the patient's condition and treatment needs (including any medications).

Exhibit III - 1 on the next page illustrates the components of a model geriatric health care program.

Exhibit III - 1

COMPONENTS MODEL GERIATRIC HEALTH CARE PROGRAM



Note: The overall goal is to mantain good health and independence of elderly in the community. The model indicates that health center services should respond to unique needs and resources in the community. External resources are essential in meeting comprehensive medical, functional and psychosocial needs of elderly patients.

Geriatric Assessment is the first step in the service delivery continuum. Care should be managed by a core geriatric team (physician, mid-level practitioner or nurse, and social worker).

From LaJolla Management Corp., Final Report on C/MHCs and Elderly Services, 1987

D. TYPES OF SERVICES AND FACILITIES NEEDED TO CARE FOR ELDERLY PATIENTS

This section provides a description and discussion of the facility and staffing requirements, and medical and ancillary services needed to operate a successful geriatric program.

1.) Types of Services

Most of the services needed by the elderly differ little from those needed by adults in general, and include:

- o medical services
- o dental services
- o social services
- o pharmacy services
- o laboratory services
- o radiology services

In addition to these basic services, the elderly have a greater need for the following services than do many other patient groups:

- o home visits/house calls
- o transportation services
- o homemaker services
- o nursing home care
- o referrals to specialists
- o help with health insurance forms and requirements

2.) Physical Facilities

C/MHCs planning for the physical space requirements of geriatric services should consider the following:

Waiting areas. Should the waiting area for elderly patients be separate from other types of patients (e.g., pediatric patients), or should a common waiting room be used? Basically, the answer to that question will depend on how the geriatric practice is structured, on space considerations, and on the preferences of the patients. In our case study research, we saw both separate and common waiting rooms used. In one site, services for the elderly were considered to be an integral part of all the services being provided for the community (i.e., a family practice approach), and a common waiting room was used. Also, the same staff was seeing all types of patients, so separate waiting rooms would not have made sense. In contrast, in a second site, separate waiting rooms for adults and children were used. In that health center, different staff was seeing adult and pediatric patients, making a differentiation more logical. One waiting room was for adult patients and fed into the exam rooms of the internists, and one waiting room was for the pediatric patients which fed into the pediatricians' area.

Examination Rooms. The most important issue to be considered, and one which can have a major impact on provider productivity, is the number of exam

rooms that each provider should be utilizing. In our case study research, the use of **three exam rooms per provider** appeared optimal. In some cases, two rooms per provider were being used, but in no case should it drop below this. The productivity of health center providers can best be supported by having three exam rooms. Because it sometimes takes an elderly person a longer time to dress and undress, the use of three rooms allows for that extra time without slowing the flow of patients through the health center.

Handicapped Access. Because the elderly are more likely to have functional limitations and mobility problems, handicapped access is important to the health center for these patients. Access includes having convenient parking facilities or transportation services.

3.) Specific Ancillary Services

Medicare covers the costs of ancillary tests ordered by a physician, but does not cover pharmacy costs.

Laboratory. The health center should have the capability to perform routine diagnostic laboratory work, and have an outside laboratory to perform more complex tests if needed. Ideally, samples to be sent to an outside lab should be drawn at the health center in order to save the patient an extra trip.

EKG and Spirometer. EKGs and spirometers for measuring pulmonary function are two important pieces of equipment that a health center should have for diagnostic work with elderly patients because of their higher incidence of cardiac and pulmonary conditions.

Radiology. Again, ideally the health center should have the ability to take and read diagnostic X-rays. More complex radiographic studies should be referred to a local hospital, if necessary.

Pharmacy. Many health centers do not have in-house pharmacy services, but several have developed low-cost programs to help their patients. This can be of particular significance to elderly patients who are often on multiple medications, and have limited budgets. In addition, Medicare does not cover prescription drug costs. One center studied has an annual drug subsidy budget which is used to reduce pharmacy costs for all patients. The health center has contracted with 10 area pharmacies to supply prescription drugs at a reduced price for its patients, with the health center using its drug budget to pay the balance of the bill to the pharmacy. At another health center, an in-house pharmacy charges reduced rates for prescriptions. The health center providers may also provide samples of prescribed medications free of charge to their patients to help reduce patient outlays for these medicines.

4.) Staffing Requirements

There are no specific requirements for specialization for providers working with the elderly. There are, however, certain attributes which are crucial for those providers to have. These include a true interest in and sensitivity to the elderly patient; interest in chronic rather than acute

conditions since a great deal of the care will be concerned with long-term illness and conditions; ability to work in a team with other disciplines; and specialized education, training or experience in treating the elderly. In addition, **continuity of staff** is vitally important to a successful elderly practice. Elderly patients, more than others, form attachments to providers. A frequent turnover in staff is extremely disruptive in geriatric practices. Support staff in health centers can provide an important source of continuity and familiarity to elderly patients.

Physician Staff. Medical services for the elderly can be provided by family practitioners, internists, osteopaths, or geriatricians (i.e., physicians with specialty training in geriatrics). All providers working with the elderly should have some further training in geriatrics because of the special health needs of the elderly, however.

Mid-level Providers. Many health centers use nurse practitioners or physician assistants to provide care to the elderly. Because these mid-level providers are not under as high productivity requirements as physicians, they are particularly valuable in an elderly practice because they can spend extra time with elderly patients if necessary for explanations, education, training, etc. According to the La Jolla study, mid-level geriatric practitioners or geriatric nurses should be used by a health center in which more than 20% of the active caseload (or at least 750 patients) are elderly.

Nurses and Clinical Assistants. Nurses and clinical assistants can augment and stream-line the care offered to elderly patients. In many health centers, nurses and clinic assistants help with all of the potentially time-consuming tasks involved in examining and treating an elderly patient, i.e., helping the patient get to the exam room and to undress and dress, taking vital signs and recording chief complaint, escorting patients to the lab if necessary, and providing education, explanations and a review of the doctor's orders. These staff members can also help to provide a sense of continuity and familiarity in health centers in which there is physician turnover.

Specialists. In order to take care of all of the health needs of the elderly, the health center will need to establish linkages with specialists, who can either provide services at the health center on a regular periodic basis (i.e., weekly or monthly), or to whom the health center can refer patients. The following specialty areas are important in caring for the elderly: cardiology, orthopedics, podiatry, oncology, urology, gastroenterology, ophthalmology, and pulmonary medicine.

E. BARRIERS TO DEVELOPMENT OF GERIATRIC PRACTICE

Barriers to developing a successful geriatric practice can exist because of the reluctance of elderly individuals to come to a community health center, or because of C/MHCs reluctance to target elderly patients.

The main reasons that the elderly might be disinclined to use C/MHCs fall into four categories:

Image. Clinic location, crowded waiting rooms, scheduling problems, and a negative reputation as a "second class" or poor people's clinic, will discourage an elderly individual from seeking care at a C/MHC.

Lack of transportation. This is an extremely serious barrier for a number of elderly, and tends to be a greater problem in rural areas.

Clinical issues. Lack of staff training and/or sensitivity to elderly issues, high physician turnover, and lack of continuity of care will also drive away elderly patients.

Financial/regulatory issues. Financial barriers including the need for services not reimbursed by third party insurance companies, prescription drug expenses, expenses of deductibles and co-payments, lack of Medicare Part B coverage, etc. Some of these factors can be controlled to a certain extent by the health center, while others cannot.

The reluctance of C/MHCs to build their elderly practices is based on several concerns that were voiced repeatedly in our work on this project. These concerns fell into three main categories:

Lack of familiarity with content of geriatric care. The elderly have complex health and social needs that may require a different constellation of health care providers, or at least a change in focus for existing providers who may be used to dealing primarily with mothers and children. Most health centers have little experience in dealing with the elderly, and are concerned about the apparent complexity and time-consuming nature of care. This chapter has attempted to clarify the requirements of geriatric care.

Reimbursement issues. Many C/MHCs are heavily dependent on 329 and 330 grants from HRSA. They are not as familiar with Medicare reimbursement and its complexities, and may not have the internal systems needed to assess the advantages or disadvantages of receiving cost-based versus fee for service reimbursement. They may have a sense that the elderly, who are known to be high utilizers of care, are an expensive group to serve. Chapter VI will describe Medicare reimbursement in detail.

Impact on productivity. The elderly have a reputation for being slow, and time-consuming patients. Since grant funding is dependent on meeting productivity standards, C/MHCs are concerned about the impact of a large number of elderly patients on their provider productivity.

In reality, even though it may take more time for an elderly patient to walk, dress and undress, it is possible to structure the practice in such a way that productivity is maintained. Several issues are involved in the productivity problem.

- Use of clinical assistants. By using clinical assistants to help the patients dress and undress, take vital signs, and record the chief complaint, physician time can be spent productively and efficiently diagnosing and treating the patient.

- o Continuity of Care. The fact that elderly patients tend to "bond" to a provider and continue to see the same physician for many years allows a physician's productivity to remain high with these patients. Even though many of these patients may have chronic conditions, they will usually present with an acute problem that takes no more time to treat than it would for any other patient. The first visit or two with these patients may take more time, but after that they will become just like other patients. As discussed earlier in this chapter, repeat visits for "old" patients are less time consuming than visits by "new" patients.

- o Alternative sites of care. Productivity is usually measured only in terms of office visits. Care for the elderly takes place at the hospital, at home, and at nursing homes, as well as at the office. Productivity calculations for physicians seeing elderly patients should include visits made at those sites as well.

Finally, research has shown that, in reality, the elderly take no more time to take care of than patients of other types. The National Center for Health Statistics (1979) found that the average duration of an office visit for all ages was 15.2 minutes, and 15.8 minutes for the elderly. By comparison, the average duration for individuals aged 25 - 44 was 16.2 minutes, and for those 45 - 64, was 16.7 minutes. An analysis performed by La Jolla Management Corporation found no difference in productivity between health centers seeing a high number of elderly patients and those seeing few elderly patients (nor could they find a change over time in the same health center as its number of elderly patients increased).

Other studies have supported these findings, as has our case research. The providers at the three health centers studied for this manual recorded the following numbers of annual encounters per FTE on their BCRRs (encounters included visits at the clinic, hospital, home and nursing home): 5,813; 4,992; and 5,885.

F. CHARACTERISTICS OF SUCCESSFUL C/MHC GERIATRIC PROGRAMS

In addition to the many requirements for a successful geriatric program described above, the following services or characteristics of C/MHC geriatric programs appear to be important to the elderly, and to help ensure that the program is successful and well-received.

Of greatest importance are the following:

Accepting Medicare assignment. Not only does this relieve patients of the complexities of claims processing and filing tasks, but it also protects them from excess charges. Medicare reimbursement will be described in detail in Chapter VI of this manual.

Sliding fee scales. Community health centers with successful elderly programs apply their sliding fee scale to the deductible and co-payment

amounts required from elderly patients by Medicare. This again helps to relieve the financial burden of care faced by many poor elderly.

Provider continuity. The importance of this aspect of geriatric care cannot be stressed too strongly. Elderly patients tend to use more services and thus have more contact with their physicians than younger patients. Establishing a stable relationship with a provider (physician or mid-level) is important for the patient's peace of mind and confidence, and also has an impact on the quality of care he receives as well as on provider productivity (i.e., being familiar with the patient's history allows him to treat the patient more quickly and effectively, with less chance of iatrogenesis). Elderly patients, to a greater extent than younger ones, value their "bonds" with a provider and need to feel like that provider is accessible and reliable.

Comprehensive care and a "team" approach. Most health centers with successful geriatric practices use a team approach to care in order to ensure that the patient's complex needs are met. This "team" can range from a physician and clinic assistant, to a team consisting of a geriatrician, geriatric mid-level provider, social worker and nurse.

Delivery of care in alternative settings. More than other patients, the elderly often need care in alternative settings (hospitals, nursing homes, home). This requires that health centers be willing to go to their patients, rather than limiting care to the health center itself. By remaining involved with their patients in these other settings, the providers are also more able to effectively manage that care and stay informed about developments in the patient's health and medical care needs.

Stable and involved support staff. In many health centers, provider turnover has historically been fairly rapid. A stable support and front-desk staff can help to bridge these changes in provider staff and provide a sense of continuity that is so important to elderly patients. The presence of a familiar face at the front desk, or well-known clinic nurse or assistant can go a long way to preserving a patient's sense of continuity and trust. In successful programs, the support staff often takes an active role in providing servicesby knowing their elderly patients by name, understanding their problems and being able to help arrange transportation, etc., and providing a personal feeling to the clinic.

Transportation system. Only one of the health centers studied maintained a clinic van to transport patients to their appointments, but all sites considered transportation to be a problem. Linkages with the aging network transportation system is one possible solution to this problem.

Attractiveness of facilities. One of the reasons that health centers have not seen a large number of elderly patients in the past is because health centers are associated with "second class" or poor people's medicine. Attractive, modern facilities and equipment, and professional staff are important factors in attracting elderly patients. In most of the sites studied, the health clinic could not be distinguished from physician offices in the area.

Established referral networks and relationships with high quality hospitals. Elderly patients want to know that if they need specialized services that cannot be provided at the health center, or if they need to be hospitalized, that the health center is able to arrange for that care with high quality providers, as close as possible to the community in which they live.

On-site specialty and dental services. Services commonly needed by the elderly - dental, orthopedic, psychological, podiatric - are provided by some health centers on site, often by contracting with physicians from neighboring communities to conduct periodic specialty clinics at the health center.

Responsiveness to needs of elderly patients, and a sense of caring and involvement. Although not a specific service or program attribute, a crucial part of a successful elderly practice is the creation of an atmosphere of caring and involvement by the clinic staff. An awareness of and responsiveness to the needs of the elderly in the community lies at the heart of this involvement, but staff attitudes and the sense of caring that they express to their patients are a critical part of program success.

Community networking. Linkages with community hospitals, the aging network, social and home service agencies in the community are also important for the health center to establish and maintain. Many elderly have complex needs that are not strictly medical, and the ability of the health center to access other types of providers and services, and ensure that their elderly patients receive services that they need are important to the overall care of their patients.

Educational, screening and outreach programs. The health center can play an important role in the health of the elderly of the community by conducting sessions on health promotion topics, providing screening services and immunizations, etc. These services are also an effective method of outreach and of establishing connections to the elderly and elderly service organizations in the community.

There are several other program characteristics or services that we found in our case studies that were not shared by all health centers, but played an important role in the success of a particular program.

Provider expertise and visibility. In one community, health center providers had taken a leading role in geriatric care in the community, and received referrals from other physicians in the community. They had established a specific geriatric care division in the health center, instituted the use of a geriatric assessment tool, and established regular geriatric clinical conferences at the local hospital.

Insurance claims assistance. One service that is highly valued by elderly patients is assistance with the filing of health insurance claims and forms. Many elderly carry supplemental and private insurance in addition to Medicare coverage. The complexity of the requirements and information can be overwhelming. It is an enormous benefit to them to have the health center simply take over that task for them.

Health center-owned home health agency. Although a health center should have a relationship with a home health agency for its patients needing home services, it is not necessary for the health center to own and operate a home health agency itself. However, some health centers do; the advantages are that they can reach the elderly in the community more effectively, and that referrals and continuity of care are simplified.

G. PROMOTION OF ELDERLY SERVICES

Health centers can utilize a number of approaches to reach and serve the elderly in the community.

Programs at senior centers or meal sites. In some communities, the senior center provides a focal point for the elderly community. By offering screening programs, immunizations, health education programs, etc. at these locations, a health center can reach a large number of elderly in the community, and advertise its existence and services.

Outreach efforts. Door-to-door visits by outreach workers can help to locate the isolated elderly. Another approach to reaching isolated elderly individuals which was used in a rural area was to get a list of individuals receiving social security checks. Contacting all providers of elderly services in a local area and building up a network of referrals is also important. Providers include meal sites, area agencies on aging, councils on aging, etc. (see Chapter IV for further information about the aging network).

Community involvement by staff of health center. A great deal of outreach and advertisement can be accomplished in an informal way through staff involvement in various community activities, including hospital or nursing home boards, boards of the area agency on aging, conducting health education classes, etc. More formally, the health center could take part in or organize a local health fair, or have a booth at a community gathering (harvest fair, spring fair, etc.).

Building of referral network. Referral networks should be built with other medical providers in the community, including other physicians and hospitals, as well as other providers of social services, such as meal sites, community service organizations, home nursing and homemaker services, etc.

Pamphlets and informational brochures. Pamphlets explaining the services offered by the health center are extremely useful for outreach purposes, and can be distributed throughout the community to individuals, and to other community organizations, agencies, and businesses with ties to the elderly.

Public service announcements. Radio stations and newspapers will generally run public service ads free of charge. This can be a no cost way of reaching a wide audience to advertise basic services or special programs.

Paid advertising. None of the health centers we talked to had used paid advertising to promote their services.

IV. SUCCESSFUL HEALTH CENTER AND ADMINISTRATION ON AGING COORDINATION EFFORTS

A. INTRODUCTION AND OVERVIEW OF THE AGING NETWORK

As discussed in earlier chapters, the needs of the elderly can be complex and often include social and supportive services as well as medical care. Many social and support services for the elderly are currently provided by the Administration on Aging (AoA) through a network of state units on aging, area agencies on aging, and local service providers. These agencies provide a comprehensive system of social services including meal programs, multipurpose senior centers, in-home care, transportation, legal services, outreach, referral, and advocacy. The aging network is an invaluable resource for C/MHCs caring for elderly patients because of its knowledge of area elderly and their needs, its access to a large number of elderly, its network of service providers (into which a C/MHC can tap), and funding for program and service development.

In order to take advantage of the aging network, it is necessary to Bunderstand its organization, responsibilities, and funding stream, particularly because the aging network is organized and funded differently than the primary care system. A brief overview of the network will be presented here, followed by a description of examples of cooperative programs developed by Area Agencies on Aging (AAAs) and C/MHCs.

The AoA is the federal agency responsible for administering the Older Americans Act of 1965. This Act established a partnership of federal, state and local governments, the private sector, and older people themselves to develop a comprehensive system of social and support services to improve the lives of older Americans. The AoA is located in the Department of Health and Human Services (DHHS), in the Office of Human Development Services. The AoA network includes the following components:

- 10 regional offices (DHHS regions)
- 57 state units on aging (in each of the 50 states, plus the District of Columbia, Puerto Rico, Virgin Islands, and 4 other territories)
- 670 area agencies on aging
- 15,000 community service organizations
- 26,046 nutrition and supportive service providers

State Units on Aging (SUA). The state unit on aging is the designated agency within the state government responsible for administering and overseeing programs for the elderly funded through the AoA. A state unit on

aging can be either an independent agency reporting directly to the governor, or a component of a larger human service agency. A C/MHC interested in obtaining information about elderly services being funded in their state, and the focus of the aging network should contact the SUA in their state. The SUA publishes annual reports, as well as planning documents and lists of the AAAs and service providers in the state. (A list of SUAs is provided at the end of this chapter.)

Area Agencies on Aging. Each state is divided into Planning and Service Areas (PSAs), with an AAA responsible for overseeing funding and programs within that area. (Some of the less populated states have only one PSA, with the SUA acting as the AAA for that state.) In some states, AAAs are umbrella agencies responsible for distributing funds to direct service providers, and monitoring programs and services. In other locations, the AAAs are also direct service providers. **Because the roles of AAAs vary from state to state, and area to area, C/MHCs may naturally link with the AAA in some locations. In other areas, however, the more natural linkage may be the direct service provider (i.e., multipurpose senior center, congregate meal site, transportation system).**

As with the SUAs, the AAAs may be a single purpose agency, or part of a multipurpose agency, such as a family service agency, etc. AAAs can be private non-profit agencies, Councils of Government (COG), or Regional Planning and Development Agencies (RPDA). It is worthwhile for a C/MHC to locate the AAA in its area and find out what services and providers it is funding. Almost all AAAs fund congregate meal sites, as well as transportation systems. (In some rural areas, the elderly network transportation system may be the only public transportation available.) The AAA will also have a great deal of information about the elderly in the area and their needs which can be of use for C/MHCs planning elderly services.

One difficulty that C/MHCs attempting to link with AAAs may encounter is differences in size and location of service areas. For example, a C/MHC service area may encompass more that one PSA, requiring that the C/MHC work with more than one AAA. In other locations, the AAA may be simply a funding agency, and the direct service providers are the logical organizations with which the C/MHC should work.

Types of Services Funded. Table V-1 on the next page lists the types of services may be provided by the AAAs directly, or through subcontracts with local service providers. C/MHCs should be aware of these services, and what agencies are providing them in order to supply this information to their elderly patients and to facilitate referrals. (C/MHCs should also ensure that the AAAs and direct service providers are aware of the C/MHC and its services, so that referrals will flow in the other direction as well.)

Funds for Program Development. The AoA also has a limited amount of funding available for support of program development, demonstration projects, and research on elderly issues. Funds may also be available directly from SUAs and AAAs. The availability of funding from the AoA, SUA, and/or AAA is worth investigating for primary care providers trying to develop or expand elderly services.

B. DESCRIPTION OF COOPERATIVE PROGRAMS

The possibilities for cooperative or coordinated programs and services between C/MHCs and AAAs (or their service providers) are numerous, and range from referrals from one agency to the other, to co-development of programs and submission of joint proposals, co-location of services, sharing of board members, etc. Some of the specific examples of cooperative programs that were revealed during case studies of four states[2] will be described briefly below to show the range and diversity of possibilities.

Submission of joint proposals.

- o C/MHC and AAA submitted a joint proposal to the AAA to fund outreach workers from the health center to reach needy elderly in the community.
- o Joint proposal submitted by AAA (a home care service provider) and C/MHC to the SUA to fund services (medical and home care) in a public housing project for the elderly.

Funding from elderly network for health centers

- o Council on Aging funded a health center to provide home nursing for frail elderly in the community, and to do hypertension screening.
- o Funds provided to health centers by SUA to perform geriatric assessments as part of a statewide program - Growing Older with Health and Wisdom.
- o AAA funded a health center to provide an outreach worker to reach poor minority elderly in community.

Co-location of services

- o Elderly clinic located at AAA site (congregate meal site, senior center, etc.)
- o Specific services provided at senior centers, such as flu shots, screenings, educational programs, physicals.
- o Elderly day program conducted in C/MHC building.
- o Congregate meal site located in C/MHC building.

---

[2] from John Snow, Inc., Final Report: "Evaluating the Collaboration of State Agencies on Aging and State Primary Care Associations on Health Service Development for the Elderly in Community and Migrant Health Centers and Area Agencies on Aging", July, 1990.

Shared staff

- AAAs and C/MHCs shared board members
- Staff from both types of agencies participated in special task forces dealing with issues of interest to the elderly.
- The director of C/MHC and director of AAA (or service provider) held regular meetings to keep each other informed and facilitate coordinated planning.
- Shared trainings were conducted, i.e., staff from health center trained AAA staff, and vice versa.
- Health center physician (or nurse) provided services at meal site.

Transportation

- Transportation system funded by AAA used to transport elderly patients to clinic.

Improved Communication/Referral System

- C/MHC placed on AAA mailing list to receive monthly newsletter.
- Referrals made from AAAs to C/MHCs, and vice versa.

Table IV - 1

Community-Based Services Funded by AoA[1]

Services to facilitate access

- Transportation
- Outreach
- Information and referral
- Client assessment and case management

Services provided in the community

- Congregate meals
- Multipurpose senior centers
- Casework, counseling, emergency services
- Legal assistance and financial counseling
- Adult day care, protective services, health screening
- Housing, residential repair and renovation
- Physical fitness and recreation
- Pre-retirement and second-career counseling
- Employment
- Crime prevention and victim assistance
- Volunteer services
- Health and nutrition education
- Transportation

Services provided in the home

- Home health, homemaker, home repairs
- Home-delivered meals and nutrition education
- Chore maintenance, visiting, shopping, letter writing, escort, and reader services
- Telephone reassurances
- Supportive services for families of elderly victims of Alzheimer's disease and similar disorders

Services to residents of care-providing facilities

- Casework, counseling, placement and relocation assistance
- Group services, complaint and grievance resolution
- Visiting; escort services
- State long-term care ombudsman program
- Other community services, as available

---

[1] from State Units on Aging: Understanding Their Roles and Responsibilities, National Association of State Units on Aging, 2nd ed., 1987.

APPENDIX A

A DIRECTORY OF THE STATE UNITS ON AGING

Alabama
Commission on Aging
State Capitol
Montgomery, Alabama 36130
(205) 261-5743

Alaska
Older Alaskans Commission
Department of Administration
Pouch C—Mail Station 0209
Juneau, Alaska 99811
(907) 465-3250

American Samoa
Territorial Administration on Aging
Office of the Governor
Pago Pago, American Samoa 96799
011 (684) 633-1252

Arizona
Aging and Adult Administration
Department of Economic Security
1400 West Washington Street
Phoenix, Arizona 85007
(602) 255-4446

Arkansas
Division of Aging and Adult Services
Department of Social and Rehabilitative Services
Donaghey Building—Suite 1428
7th and Main Streets
Little Rock, Arkansas 77201
(501) 371-2441

California
Department of Aging
1600 K Street
Sacramento, California 95814
(916) 322-5290

Colorado
Aging and Adult Services Division
Department of Social Services
717 17th Street
PO Box 181000
Denver, Colorado 80218-0899
(303) 294-5913

Connecticut
Department on Aging
175 Main Street
Hartford, Connecticut 06106
(203) 566-3238

Delaware
Division on Aging
Department of Health and Social Services
1901 North DuPont Highway
New Castle, Delaware 19720
(302) 421-6791

District of Columbia
Office on Aging
Office of the Mayor
1424 K Street, N.W., 2nd Floor
Washington, D.C. 20011
(202) 724-5626

Florida
Program Office of Aging and Adult Services
Department of Health and Rehabilitation Services
1317 Winewood Boulevard
Tallahassee, Florida 32301
(904) 488-8922

Georgia
Office of Aging
878 Peachtree Street, N.E., Room 632
Atlanta, Georgia 30309
(404) 894-5333

Guam
Public Health and Social Services
Government of Guam
Agana, Guam, 96910

Hawaii
Executive Office on Aging
Office of the Governor
335 Merchant Street, Room 241
Honolulu, Hawaii 96813
(808) 548-2593

Idaho
Idaho Office on Aging
Room 114-Statehouse
Boise, Idaho 83720
(208) 334-3833

Illinois
Department on Aging
421 East Capitol Avenue
Springfield, Illinois 62701
(217) 785-2870

Indiana

Department on Aging and Community Services
251 North Illinois Street
PO Box 7083
Indianapolis, Indiana 46207-7083
(317) 232-7006

Iowa

Deparment of Elder Affairs
Suite 236—Jewett Building
914 Grand Avenue
Des Moines, Iowa 50319
(515) 281-5187

Kansas

Department on Aging
610 West Tenth
Topeka, Kansas 66612
(913) 296-4986

Kentucky

Division for Aging Services
Department of Human Resources
DHR Building—6th Floor
275 East Main Street
Frankfort, Kentucky 40601
(502) 564-6930

Louisiana

Office of Elderly Affairs
PO Box 80374
Baton Rouge, Louisiana 70898
(504) 925-1700

Maine

Bureau of Maine's Elderly
Department of Human Services
State House—Station #11
Augusta, Maine 04333
(207) 289-2561

Maryland

Office on Aging
State Office Building
301 West Preston Street, Room 1004
Baltimore, Maryland 21201
(301) 225-1100

Massachusetts

Executive Office of Elder Affairs
38 Chauncy Street
Boston, Massachusetts 02111
(617) 727-7750

Michigan

Office of Services to the Aging
P.O. Box 30026
Lansing, Michigan 48909
(517) 373-8230

Minnesota

Board on Aging
Metro Square Building, Room 204
Seventh and Robert Streets
St. Paul, Minnesota 55101
(612) 296-2544

Mississippi

Council on Aging
301 West Pearl Street
Jackson, Mississippi 39203-3092
(601) 949-2070

Missouri

Division on Aging
Department of Social Services
P.O. Box 1337
505 Missouri Boulevard
Jefferson City, Missouri 65102
(314) 751-3082

Montana

Community Services Division
PO Box 4210
Helena, Montana 59604
(406) 444-3865

Nebraska

Department on Aging
PO Box 95044
301 Centennial Mall—South
Lincoln, Nebraska 68509
(402) 471-2306

Nevada

Division on Aging
Department of Human Resources
505 East King Street
Kinkead Building, Room 101
Carson City, Nevada 89710
(702) 885-4210

New Hampshire

Council on Aging
105 Loudon Road—Building 3
Concord, New Hampshire 03301
(603) 271-2751

New Jersey

Division on Aging
Department of Community Affairs
PO Box 2768
363 West State Street
Trenton, New Jersey 08625
(609) 292-4833

New Mexico

State Agency on Aging
La Villa Rivera Building—4th Floor
224 East Palace Avenue
Santa Fe, New Mexico 87501
(505) 827-7640

New York

Office for the Aging
New York State Plaza
Agency Building 2
Albany, New York 12223
(518) 474-4425

North Carolina

Division on Aging
Kirby Building
1985 Umpstead Drive
Raleigh, North Carolina 27603
(919) 733-3983

North Dakota

Aging Services
Department of Human Services
State Capitol Building
Bismarck, North Dakota 58505
(701) 224-2577

Northern Mariana Islands

Office of Aging
Department of Community and Cultural Affairs
Commonwealth of Northern Mariana Islands
Civic Center—Susupe
Saipan, Northern Mariana Islands 96950
Tel. Nos. 9411 or 9732

Ohio

Department on Aging
50 West Broad Street—9th Floor
Columbus, Ohio 43215
(614) 466-5500

Oklahoma

Special Unit on Aging
Department of Human Services
PO Box 25352
Oklahoma City, Oklahoma 73125
(405) 521-2281

Department of Human Services
Aging Services Division
312 N.E. 28th Street
Oklahoma City, Oklahoma 73105
(405) 521-2327

Oregon

Senior Services Division
313 Public Service Building
Salem, Oregon 97310
(503) 378-4728

Pennsylvania

Department of Aging
231 State Street
Harrisburg, Pennsylvania 17101-1195
(717) 783-1550

Puerto Rico

Gericulture Commission
Department of Social Services
PO Box 11398
Santurce, Puerto Rico 00910
(809) 721-3141 or 722-0225

Rhode Island

Department of Elderly Affairs
79 Washington Street
Providence, Rhode Island 02903
(401) 277-2858

South Carolina

Commission on Aging
915 Main Street
Columbia, South Carolina 29201
(803) 758-2576

South Dakota

Office of Adult Services and Aging
Kniep Building
700 North Illinois Street
Pierre, South Dakota 57501
(605) 773-3656

Tennessee

Commission on Aging
715 Tennessee Building
535 Church Street
Nashville, Tennessee 37219
(615) 741-2056

Texas

Department on Aging
PO Box 12768—Capitol Station
1949 IH/35, South
Austin, Texas 78741-3702
(512) 444-2727

Trust Territory of the Pacific Islands

Office of Elderly Programs
Community Development Division
Government of TTPI
Saipan, Mariana Islands 96950
Tel. Nos. 9335 or 9336

Utah

Division of Aging and Adult Services
Department of Social Services
Box 45500
150 West North Temple
Salt Lake City, Utah 84145-0500
(801) 533-6422

Vermont

Office on Aging
103 South Main Street
Waterbury, Vermont 05676
(802) 241-2400

Virgin Islands

Commission on Aging
6F Havensight Mall—Charlotte Amalie
St. Thomas, Virgin Islands 00801
(809) 774-5884

Virginia

Department on Aging
James Monroe Building—18th Floor
101 North 14th Street
Richmond, Virginia 23219
(804) 225-2271

Washington

Bureau of Aging and Adult Services
Department of Social and Health Services
OB-44A
Olympia, Washington 98504
(206) 586-3768

West Virginia

Commission on Aging
Holly Grove—State Capitol
Charleston, West Virginia 25305
(304) 348-3317

Wisconsin

Bureau of Aging
Division of Community Services
One West Wilson Street, Room 453
Madison, Wisconsin 53702
(608) 266-2536

Wyoming

Commission on Aging
Hathaway Building, Room 139
Cheyenne, Wyoming 82002-0710
(307) 777-7986

V. MEDICARE REIMBURSEMENT

A. MEDICARE ADMINISTRATION

1.) Overview of the Medicare Program

The Medicare Amendments to the Social Security Act (Title XVIII) adopted in 1965, established a health insurance system for the eligible elderly and disabled individuals. Under this program physicians, hospitals and other health care providers are reimbursed directly for covered services provided to Medicare beneficiaries.

Medicare is a federal program providing two types of health insurance: Part A and Part B. Part A provides reimbursement for inpatient hospital, skilled nursing, hospice, home health and related care. Part B provides reimbursement for physicians' services, outpatient hospital services, comprehensive outpatient rehabilitation facility, ambulatory surgical, and other medical services. Whereas Part A is automatic for all Social Security Act (SSA) beneficiaries, Part B is an optional program that beneficiaries must pay for through a deduction to their monthly Social Security checks. Furthermore, beneficiaries participate in the cost of Medicare services through both a $75 annual deductible payment, and a 20% co-payment of allowed charges for each service.

Regulations implementing the Medicare Program are defined in Title 42 of the Code of Federal Regulations (CFR).

2.) Administration of the Medicare Program

Overall responsibility for administration of the Medicare Program rests with the Secretary of Health and Human Services. Primary responsibility within the Department of Health and Human Services for administering Medicare programs belongs to the Health Care Financing Administration (HCFA). HCFA provides operational direction and policy guidance for the administration of the Medicare program.

The Health Care Financing Administration is headed by the HCFA Administrator, who is appointed directly by the President. HCFA maintains ten regional offices located in Atlanta, Boston, Chicago, Dallas, Denver, Kansas City, New York, Philadelphia, San Francisco, and Seattle.

As part of its administrative function, HCFA negotiates and administers agreements with Medicare fiscal intermediaries and carriers which perform payment and program functions, and with state agencies which certify health facilities for participation in the program.

The Railroad Retirement Board participates in the administration of Medicare when it affects railroad retirement beneficiaries, and the Social Security Administration remains responsible for the initial enrollment of beneficiaries and for maintaining current listings of beneficiaries.

3.) Fiscal Intermediaries and Carriers

In order to carry out its payment and program functions for Part A of Medicare, HCFA contracts with external organizations. These organizations are typically large insuring entities such as Blue Cross/Blue Shield organizations, and they are referred to as Part A intermediaries. It is the intermediaries' responsibility to administer payments to hospitals and other Part A providers.

Their Part B counterparts are referred to as carriers. The carriers have responsibilities similar to the intermediaries except that the carriers are handling payments to physicians, ambulatory care, and other Part B suppliers of health care services and equipment.

Usually, there is one intermediary and one carrier per state.

As will be discussed later, there are separate intermediaries that are used for the specialized cost-based rate programs for (federally funded) C/MHCs and Independent Rural Health Clinics. There is one national intermediary, currently the Aetna Life and Casualty Company based in Peoria, IL, administering the Federally Funded Health Center (FFHC) program.

Currently, there are six intermediaries (sometimes referred to as carriers because they handle Part B services) contracted to administer the Rural Health Clinic Program. These are listed in Table V-1 on the next page.

Table V-1

List of Intermediaries for the Rural Health Clinic Program

Intermediaries	States Served
Aetna Life Insurance Co. Petaluma, California	Alaska, Arizona, California, Guam, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nevada, Nebraska, Ohio, Oregon, Samoa, Washington, Wisconsin
Associate Hospital Service of Maine, DBA Maine Blue Cross and Blue Shield Portland, Maine	Maine
Blue Cross and Blue Shield of Tennessee Chattanooga, Tennessee	Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee
Blue Cross of Western Pennsylvania Pittsburgh, Pennsylvania	Connecticut, Delaware, Maryland, Massachusetts, New Jersey, New York, Pennsylvania, Rhode Island, Virginia, West Virginia
Rocky Mountain Hospital and Medical Service, DBA Blue Cross and Blue Shield of Colorado Denver, Colorado	Arkansas, Colorado, Louisiana, Montana, New Mexico, North dakota, Oklahoma, South Dakota, Texas, Utah, Wyoming
New Hampshire-Vermont Health Service, Inc. Concord, New Hampshire	New Hampshire, Vermont

B. REIMBURSEMENT MODES AVAILABLE TO COMMUNITY/MIGRANT HEALTH CENTERS (C/MHCs)

Community and Migrant Health Centers (C/MHCs) have three possible avenues for Medicare reimbursement: 1) average cost per visit reimbursement as a certified Rural Health Clinic, 2) average cost per unit reimbursement as a qualified Federally Funded Health Center, 3) traditional charge based reimbursement, or 4) capitation payment through a Medicare health maintenance organization (HMO) contract.

Medicare HMOs are managed care programs for persons eligible for Medicare benefits. A C/MHC involved in a Medicare HMO would receive a capitation payment (fixed sum per enrollee) in exchange for providing certain health care services. Although this reimbursement mode is included in the list of reimbursement modes available for C/MHCs, a full discussion of this alternative is not included in this manual. A discussion on reimbursement through Medicare HMO contracts requires a separate text, and would cover the concepts and variations of managed care, including the financial risks assumed in such arrangements, and the administrative systems required to monitor and control the utilization and costs of services provided to enrollees.

1.) Rural Health Clinic Reimbursement

In December 1977, Congress passed the Rural Health Clinic Services Act of 1977 (Public Law 95-210) to channel financial support to facilities which use physician extenders to provide primary health care in rural, medically undeserved areas. This law authorizes Medicare to make payments to qualified Rural Health Clinics for covered health care services furnished by or under the direction of nurse practitioners and physician assistants, even though the facility may not be under the full-time direction of a physician.

A C/MHC can qualify as a rural health clinic if it meets the following requirements:

- Is under the general direction of a physician;
- Is located in a rural area as defined by the Bureau of Census;
- Operates in an manpower shortage area as designated by the Department of Health and Human Services; and
- Has at least one (1) qualified physician assistant, nurse practitioner, or certified nurse mid-wife who is legally permitted by State regulations to perform the professional services covered by Medicare reimbursement, and who is available to furnish patient care services not less than 50% of the time the clinic operates.

In general, the law requires that reimbursement to RHCs be made on the basis of costs which are reasonable and related to the cost of providing rural health services. Rural health services include:

- o Physicians' services that are performed by a physician at the clinic or are performed away from the clinic by a physician whose agreement with the clinic provides that he or she will be paid by the clinic for such services;

- o Nurse practitioner, physician assistant, and nurse mid-wife services that would be covered if furnished by a physician, provided that the nurse practitioner or physician assistant is employed by the clinic and is legally permitted to perform the services by the State in which they are performed;

- o Services and supplies incident to the services of the provider;

- o Visiting nurse services to the homebound if the RHC is located in an area designated as having a shortage of home health agencies and if services are delivered within home health agency regulations; and

- o Clinical psychologists and clinical social workers' services.

A Rural Health Clinic may provide other items or services which are covered under Part B, but which are not rural health services. These items and services include:

- o Durable medical equipment;

- o Ambulance services;

- o Prosthetic devices; and,

- o Contracted physical, speech, or occupational therapy.

The distinction between rural health services and other medical and health services is important because of the difference in reimbursement. Rural health services are reimbursed on a **cost basis** through an average cost per visit rate. Other medical and health services, i.e. non rural health services are reimbursed on a reasonable charge basis.

Rural Health Clinics are divided into two classifications: provider and independent. Provider Rural Health Clinics are an integral part of a hospital, skilled nursing facility, or home health agency. Medicare reimbursement to provider Rural Health Clinics is based on the cost reimbursement principles used for reimbursing the covered services furnished by the participating provider, i.e. hospital, skilled nursing facility, or home health agency. Non provider Rural Health Clinics (i.e. independent clinics and most C/MHCs) are reimbursed on the basis of an all-inclusive rate for each beneficiary visit for covered services. The methodology for determining the all-inclusive rate is described below.

a.) All-inclusive rate determination

Independent Rural Health Clinics are reimbursed by Medicare based on an all-inclusive rate per visit. The all-inclusive rate is computed by the RHC's designated Medicare intermediary. The fiscal intermediary computes the rate using projected cost and volume information supplied by the RHC at the beginning of each reporting period.

Basically, the all-inclusive rate is computed by dividing allowable costs by total allowable encounters, including clinic and home visits by physicians, mid-levels, and/or clinical social workers and psychologists, and hospital visits by physicians or clinical psychologists.

b.) Determination of allowable costs

Allowable costs are those costs necessary to provide rural health services. The following costs are considered costs of providing rural health services and are included in allowable costs to the extent they are reasonable:

- Compensation paid to physicians, physician assistants, nurse practitioners, nurse midwives, visiting nurses, and clinical psychologists and social workers who are employed by the clinic. All physician services performed at the RHC are considered to be rural health services. Physician services performed off site are considered rural health services if the physician is compensated for these services by the clinic.

- Compensation paid to the supervising physician for contracted services.

- Costs of services and supplies incident to provider services.

- Administrative overhead including occupancy costs and depreciation which are related to providing rural health services. The amount of overhead related to rural health services is based upon the ratio of rural health service direct costs to total direct cost of all services.

- Costs of services purchased by the clinic.

- Uncollectible deductibles and coinsurance for Medicare visits subject to collection effort requirements. Uncollectible deductibles and coinsurance is equal to the total amount billed to Medicare patients during the period less the amount collected less recovery of prior period bad debt. Uncollectible deductibles and coinsurance are reimbursable only if the RHC has made reasonable efforts of collection for 120 days after the date of service. Description of required collection procedures and sample collection letters are included in the appendices.

c.) Tests of reasonableness and reimbursement limits

Selected costs related to providing rural health services are tested for reasonableness, to include for example, the compensation paid to providers. Moreover, there are specific standards for productivity and limits on the all-inclusive rate.

1. Productivity

HCFA has established minimum productivity standards for providers employed by a rural health clinic. The current productivity standards are 4,200 visits for physicians and 2,100 visits for physician assistants and nurse practitioners. Productivity standards do not apply to contracted providers. Productivity standards are applied when computing the allowable cost per visit. That is, if a rural clinic's actual visits are less than 4,200 per FTE for physicians and 2,100 for mid-levels, the intermediary may divide total allowable costs by the visit standards, rather than the clinic's actual number of visits. This would yield a reimbursement rate that is lower than the clinic's actual cost per visit.

It is important to note that intermediaries have authority to waive productivity guidelines in cases where a clinic has demonstrated reasonable cause for not meeting the standard. The fiscal intermediary could either accept the clinics actual number of visits or establish a standard lower than the 4,200 and 2,100 thresholds.

2. Overall Limit

The all-inclusive rate is the lower of the RHC's allowable cost per visit or the payment limit established by HCFA. The payment limit is established each year for services rendered on or after January 1 of each year. The payment limit is increased by the percentage increase in the Medical Economic Index. The payment limit effective as of January 1, 1989 was $47.38.

Rural Health Centers receive full cost reimbursement from Medicare for providing pneumococcal vaccine to Medicare beneficiaries. The all-inclusive rate and final settlement computations have been adjusted accordingly.

The costs of providing non-rural health services are not included in the all-inclusive rate. These services are billed and reimbursed on a reasonable charge basis. Non-rural health services include: durable medical equipment, ambulance services, outside therapy, and prosthetics.

d.) Reimbursement

RHCs are reimbursed 80% of the approved all-inclusive rate less any applicable deductible for each rural health clinic service visit. Essentially, the all-inclusive rate is an interim rate paid by Medicare during the reporting period. The total reimbursement due the RHC from Medicare is based upon the actual cost of providing services as reported at the end of the reporting period. The difference between interim payments and actual costs is reconciled at the end of the period, and any amount due to/from Medicare is

determined. If an amount is due Medicare, the RHC can spread payments over the next fiscal year, if necessary. If an amount is due the RHC, a lump sum payment is made to the RHC. Intermediaries typically are very careful not to overestimate the interim cost rate which would result in amounts due from the clinic to the intermediary.

Filing of cost reports and computing final settlement is discussed in more detail under Section III.

2.) Federally Funded Health Center Reimbursement

Comprehensive federally funded health centers can elect to be reimbursed by Medicare on a reasonable cost basis if they meet certain criteria. In order to qualify for cost-based reimbursement, a center must meet the following requirements:

- o A health center must maintain an adequate cost accounting system to permit rate calculation; and
- o A health center must provide a sufficient number of Medicare visits to make cost-based reimbursement practical. The number of visits needed to qualify is defined by HCFA.

Medicare no longer requires that a center be physician directed in order to qualify for cost-based reimbursement. However, the guidelines for Medicare reimbursement have not changed. Medicare will reimburse centers only for physician services and services incident to physician services. In order for the "incident to" requirement to be met, a physician must be present in the center and available to provide assistance and direction. The method for computing the all-inclusive rate has been modified to account for these changes. Therefore, under FFHC, mid-level encounters are only billable when the physician is present in the clinic.

Independent federally funded health centers which qualify for cost-based reimbursement (herein after referred to as "Federally Funded Health Centers" or "FFHC's") are reimbursed by Medicare for covered services furnished to Medicare beneficiaries on the basis of a prospectively determined all-inclusive rate. The methodology for determining all-inclusive rate is outlined below.

a.) All-inclusive rate determination

Basically, the all-inclusive rate is computed by dividing the center's projected allowable costs by projected number of physician visits, subject to certain screening guidelines and payment limit.

The first step in computing the all-inclusive rate is to classify the health center' costs into two categories: direct costs and overhead costs. Direct cost are then further classified into three categories: costs of physician services, costs of support services and non-allowable costs. Similarly, overhead costs are identified as allowable and non-allowable.

b.) Calculation of Allowable Direct Costs

Allowable direct costs for the purpose of Medicare reimbursement is equal to physician costs plus a certain portion of support costs.

Physician costs include compensation to physicians for providing medical services. Payments to physicians for administrative, advisory, or other services are not included as physician costs; these costs are considered to be overhead costs.

Support costs include:

- Compensation to nursing and other medical assistant staff;
- Compensation to mid-level practitioners;
- Cost of ancillary services such as diagnostic laboratory and radiology; and
- Services and supplies incident to a physician's professional services.

Because Medicare pays only for physician services, the all-inclusive rate includes only that portion of support costs related to physician services. The amount of support cost allowed is based upon the percent of total visits furnished by a physician at the FFHC. Whereas the RHC program allows, if not encourages, reimbursement for the use and cost of mid-level providers, the FFHC program does not: the greater the percentage of visits provided by the mid-levels, the lower the percentage of direct costs that will be allowed under FFHC. In order to receive reimbursement for mid-levels' costs, FFHC's should consider mid-level visits as physician visits when the physician is on-site and sees the patient at least briefly. These should be billed as physician visits.

The rate determination method does not require an adjustment for non-covered physician services such as immunizations and routine physical exams.

Non-allowable direct costs include the direct costs incurred by the health center for providing non-Medicare covered services. These include: optometry, pharmacy, dental, and social services.

c.) Calculation of Allowable Overhead Costs

Overhead costs are included in the all-inclusive rate calculation as an overhead rate applied to the allowable direct cost per visit. As with direct costs, the health center's indirect or overhead costs are first classified as allowable or non-allowable costs.

Allowable overhead costs include:

- o Facility costs, i.e. rent, utilities, insurance;
- o Administrative costs, i.e. physician compensation related to administrative functions, clerical staff compensation, office supplies, telephone, answering service;
- o Management costs, i.e. executive management compensation, management contract fees.

Non-allowable overhead costs for FFHC's are those defined as non-reimbursable under Medicare reimbursement principles. Examples of non-allowable overhead costs include:

- o Marketing and advertising;
- o Non-allowable interest costs;
- o Medical research costs; and
- o Discount allowances.

The overhead rate is computed by dividing total allowable overhead costs by total direct costs incurred by the FFHC including non-allowable costs.

d.) Tests of Reasonableness and Limits on Reimbursement

HCFA has several tests of reasonableness and limits on reimbursement related to Medicare reimbursement for FFHC's under cost-based reimbursement. These are outlined below.

1. Overhead Rate

The overhead rate used to compute the all-inclusive rate is the lesser of the health center's actual rate or HCFA's limit for overhead costs. Currently, overhead cost is limited to 30% of the FFHC's total direct cost.

2. Support Staff

Compensation for support staff is limited to reasonable compensation for four (4) support medical personnel (nurses, technicians, physician assistants, nurse practitioners, etc.) for each FTE physician. A full time equivalent physician is defined as providing at least 1,600 hours of direct patient care per year.

3. Productivity

Productivity standards are stated in terms of minimum number of visits per hour. Productivity standards differ by the number of years of FFHC operation. The current screening guidelines are:

Year of FFHC Operation	Visits/ Hour
1st Year	1.2
2nd Year	1.5
3rd Year	1.8
4th Year	2.1
5th Year	2.4
After 5th Year	2.4

The productivity standards are used in computing the cost per visit.

e.) Reimbursement Limit

The all-inclusive rate is limited to the statewide payment limit calculated annually from maximum area prevailing charges for services similar to those provided by FFHC's. A list of current limits by state is included in the appendices. In addition, there is a limit for mental health visits. Currently, mental health visits are reimbursed at 62.5% of the rate for medical visits.

f.) Reimbursement

FFHC's are reimbursed the approved all-inclusive rate less any unmet deductible, less 20% coinsurance of the remaining amount, for each covered visit. Essentially, the all-inclusive rate is an interim rate paid by Medicare during the reporting period. The total reimbursement due the FFHC from Medicare is based upon actual cost of providing services as reported at the end of the reporting period.

Patient amounts (deductible and coinsurance) are currently based on the FFHC's cost-based rate instead of actual Medicare-allowed charges for the visit (see Reimbursement Process, Section III).

The filing of cost reports and computing of final settlements is discussed in more detail in Section III.

3.) Charge-Based Reimbursement

Federally funded health centers which do not qualify for cost based reimbursement or which choose not be reimbursed on a cost basis, are reimbursed by Medicare on a reasonable charge basis for covered services provided to Medicare beneficiaries.

Services covered under Part B Medicare include:

- Physician services
- Medical supplies, services, and equipment;
- Renal dialysis;

- o Durable medical equipment;
- o Ambulance services
- o Ambulatory surgical care

a.) Reimbursement

Currently, the health center is reimbursed on the basis of **reasonable charges** subject to a 20% coinsurance and annual $75 (per beneficiary) deductible. Generally, the reasonable charge for a specific service is the lowest of the health center's **customary** charge for that service, the **prevailing** charge for similar services in the locality, and the physician's **actual** charge billed for that service. Amounts billed that exceed the allowed amount are written-off as contractual allowances by Participating Providers and Non-Participating Providers when they accept assignments. This amount is also referred to as the "disallowed amount".

A health center's customary charge is based upon the actual charges for services rendered in the preceding calendar year. The customary charge is determined by the carrier by arranging actual charges (for that provider) for a given service in ascending order and selecting the lowest actual charge which is high enough to include the median.

The prevailing charge is the charge most frequently and widely used in a locality for a particular procedure or service. The prevailing charge is computed as the lowest customary charge which is high enough to include 75% of customary charges for the service within the defined locality. Prevailing charges are computed separately for Participating and Non-Participating physicians (Non-Participating rates are 95% of Participating rates). Prevailing rates are capped each year by the Medicare Economic Index (MEI) determined by Congress. Therefore, prevailing rates do not truly reflect current market rates for medical services.

The actual reimbursement to the health center is 80% of the reasonable charges less any remaining deductible.

However, beginning in April, 1990, the reasonable charge method is going to be phased out over a four year period. In its place will be the Resource-Based Relative Value System (RBRVS). The RBRVS was developed by Harvard researchers to more closely reflect the true costs incurred providing medical services. RBRVS proponents hope that the system will eventually eliminate the current reimbursement bias which favors (especially invasive) procedural services over cognitive care. A Congressional advisory body, the Physician Payment Review Commission (PPRC) projects that Medicare payments will increase for internal medicine by 16%, for family practice by 37%, and for obstetrics and gynecology by 1%. On the other side the PPRC expects fee reductions of 21% for radiology, 10% for orthopedic surgery, and 20% for thoracic surgery. These results would obviously favor health centers.

The implementation of the RBRVS is intended to lead to a nationally

uniform Medicare fee schedule based upon relative value units, replacing the current system of rates based upon actual physicians' fees billed.

b.) Assignment

Medicare "Assignment" indicates an agreement between a physician and a Medicare enrollee. Under this agreement, the enrollee transfers to the physician the right to reimbursement benefits based on covered services specified on the assigned claim. The physician submits the claim form and receives payment directly. In addition, the physician agrees to accept the reasonable charge determined by the Medicare carrier as payment in full.

The physician is allowed to bill the patient any deductible and coinsurance based upon the reasonable charge determination. In addition, the patient can be billed for any services not covered by Medicare benefits. Technically, HCFA does not allow any provider to waive any part of the patients' deductible and coinsurance payments due. However, many C/MHCs waive part of these amounts through a sliding scale discount mechanism due to 330/329 requirements. Resolution of this conflict in regulations is planned in the future via a special waiver for C/MHCs.

c.) Participation Program

Participating providers are providers who enter into an agreement with Medicare to accept assignment for all services provided to all Medicare beneficiaries. A participation agreement must be signed by the provider before the year in which it is effective, a requirement not applied to newly practicing physicians. New physicians can join the program any time during the year. Participation agreements are usually effective for one year, but are automatically renewed unless cancelled by either party. All C/MHCs and their physicians are required to be Participating Providers; C/MHCs should ensure that signed agreements are in place for all providers.

Physicians who choose not to be a participating providers can still accept assignment on a case by case basis. In any case, non-participating physicians are not able to charge more than the physicians' maximum allowable charges (MAAC). This requirement, in effect, limits the amount that a non-participating physician can "balance bill" the patient for the disallowed portion of the actual charge. Participating providers' fee schedules are not limited by MAACs because, by definition, these providers have agreed to take assignment on <u>all</u> claims and write-off any disallowed amounts.

4.) <u>Advantages and Disadvantages of Each Reimbursement Mode</u>

In general, the advantages of one reimbursement mode over another depend upon each C/MHC's specific circumstances, for example, the Medicare prevailing charges for high volume C/MHC services in the area. Possible advantages and disadvantages with each mode of reimbursement include:

Rural Health Clinic Reimbursement

Advantages

- Nursing home visits are not specifically identified in determining the all-inclusive rate and are, thereby, not subject to the limit of one nursing home visit per month per patient.
- Covered services furnished by providers other than physicians, i.e. physician assistants and nurse practitioners are reimbursable.
- Bad debt costs resulting from billings for Medicare deductibles and coinsurance are reimbursable.
- Cost of providing pneumococcal vaccine is 100% reimbursable.
- Potential for reimbursement above prevailing charge.

Disadvantages

- Reimbursement mode requires becoming a certified RHC, which requires employment of at least a 0.5 FTE mid-level providers in each RHC site. C/MHCs often have difficulty recruiting and retaining mid-levels.
- Adequate accounting system is needed to produce information necessary to complete cost report.
- Requires filing of cost report.
- Medicare claims must be submitted on the UB-82 insurance form instead of the HCFA-1500 which is used for all other third party claims. Standard CPT-4 codes are not used on these UB-82 forms.
- Cash flow can be a problem between the time charge-based reimbursement payments stop and RHC payments begin.

Federally Funded Health Center Reimbursement

Advantages

- Nursing home visits are not specifically identified in determining the all-inclusive rate and are, thereby, not subject to the limit of one nursing home visit per month per patient.
- Bad debt costs are reimbursable.

- Potential for reimbursement above prevailing charge.

Disadvantages

- Reimbursement mode requires becoming a qualified FFHC.
- Adequate accounting system is needed to produce information necessary to complete the cost report.
- Standard CPT-4 codes are not used on claim forms; one single visit code is used.
- Requires filing of projected, semi-annual and annual cost reports.
- Services furnished by providers other than physician are not fully reimbursable.
- Providers must meet minimum provider productivity thresholds to receive 80% of cost of visit.
- Cash flow can be a problem between the time charge-based reimbursement payments stop and RHC payments begin.

Charge-Based Reimbursement

Advantages

- Not required to file cost report.
- Potential for reimbursement above cost.

Disadvantages

- Bad debt costs are not directly reimbursable.
- Reimbursement for nursing homes visits is limited to one per month per patient.
- Reimbursement is sometimes limited by coding regulations,

C. THE REIMBURSEMENT PROCESS

1.) Initiating a New Reimbursement Mode

a.) Rural Health Clinics

Prior to receiving reimbursement in accordance with the Rural Health Act, a C/MHC must become certified as a Rural Health Clinic. In general, there are three steps to becoming certified as a Rural Health Clinic:

1. Submit a Request to Establish Eligibility (HCFA Form 29).

2. Qualify for state certifying recommendation.

3. Sign an agreement with the Secretary of DHHS.

Applications forms and specific information about becoming a certified Rural Health Clinic can be obtained from the appropriate state certifying agency. A list of these agencies is included in the appendices.

In addition, the health center must provide to its HCFA Regional Office assurance that it has the resources and/or systems to provide necessary cost and visit information.

Assuming these conditions are met, the appropriate HCFA Regional Office issues a provider number to the Rural Health Clinic and notifies the appropriate Medicare intermediary. In turn, the intermediary sends the RHC necessary forms and information needed for filing cost reports and claims. A list of intermediaries for RHCs is provided in the appendices.

b.) Federally Funded Health Centers

A Community/Migrant Health Center which does not qualify as a Rural Health Center can obtain cost based reimbursement from Medicare as a qualified Federally Funded Health Center. The steps involved in becoming a qualified Federally Funded Health Center are outlined below:

- The health center contacts its respective Health Care Financing Administration Regional Office (HCFA RO)

- The HCFA RO sends a questionnaire to the health center for completion. The health center completes questionnaire and returns it to HCFA RO. A sample questionnaire is including in the appendices.

- A representative from the HCFA RO visits the facility. During the visit the HCFA RO representative will ascertain that the facility meets the requirements for becoming a qualified FFHC, i.e. that the health center maintains adequate accounting records for completing cost reports and that the health center has an adequate number of Medicare visits per year.

Assuming the C/MHC meets the criteria for qualification, the HCFA Regional Office will assign a provider number to the newly qualified FFHC. The RO will also notify Aetna, Medicare's fiscal intermediary for FFHC's. In turn, Aetna sends to the FFHC: 1) a cost reporting package (HCFA 242 with instructions) and 2) a new provider questionnaire. A copy of the cost report and questionnaire is included in the appendices.

c.) Charge Based Health Centers

C/MHC's can arrange for Medicare reimbursement through their respective Medicare carrier. To become a participating Medicare provider, the C/MHC must sign a participation agreement. Information and forms necessary for becoming a participating provider can be obtained from the C/MHC's Medicare carrier. A list of Part B Medicare carriers is included in the Appendix.

2.) Claims Processing

Reimbursement for services is obtained by submitting claims to the provider's designated intermediary or carrier. The basic steps for filing and processing of claims is as follows:

- Provider submits claim to the intermediary or carrier upon completion of services for each covered visit. Claims are filed on form HCFA 1500.
- Intermediary or carrier determines eligibility of benefits and deductible status.
- Intermediary or carrier determines the amount of payment due the provider and makes payment to the provider.
- The provider receives payment with supporting information in form of a remittance advice.
- The intermediary or carrier forwards an Explanation of Medicare Benefits (EOMB) to the patient.

Specific procedures for filing claims will depend upon the policies and procedures established by the health center's designated intermediary or carrier. The appropriate C/MHC staff should meet with a representative from the intermediary and/or carrier to discuss the process in detail and to establish a working relationship.

A Medicare claim is filed for each visit regardless of the reimbursement mode. That is, health centers which are reimbursed under cost based reimbursement must still file a claim for each covered visit.

Medicare reimburses the provider 80% of the allowable charge subject to any remaining deductible. The allowable charge is either the predetermined all inclusive rate or a reasonable charge, as outlined below.

Rural Health Center:	
Rural Health Service	All-inclusive rate
Other service	Reasonable charge
Federally Funded Health Center	All-inclusive rate
Charge Based	Reasonable charge

3.) Deductible and Co-Insurance Payments

In general, Medicare pays the allowable charge less 1) any remaining deductible and 2) 20% coinsurance of the remaining amount. For example, consider the following situation when a patient has $40.00 in approved charges and $10.00 in unmet Part B deductible for the year. Medicare and patient payment responsibilities, respectively, are calculated as follows:

Approved Charges	$40.00	
Less Unmet Deductible	-10.00	
	30.00	
Less 20% Coinsurance	- 6.00	(.20 x $30)
Medicare Responsibility to C/MHC	$24.00	
Patient Responsibility to C/MHC	16.00	($10 Deductible + $6 Coinsurance)
Total; Medicare + Patient.....	$40.00	

The health center collects from the patient the 20% coinsurance plus any remaining deductible up to the allowable amount.

There are two issues regarding deductible and coinsurance for those health centers which are reimbursed on a cost basis (i.e. RHC or FFHC).

First, for Federally Funded Health Centers, the amount of coinsurance due from the patient is computed as 20% of the all-inclusive rate paid to the health center. The problem arises in that the all-inclusive rate is most likely not equal to the actual charges incurred by the patient and recorded on the encounter form and, therefore, could cause confusion for the patient. In addition, if the all-inclusive rate is greater than the patients actual charges, the patient is paying a higher amount than if he or she would have received services from a clinic under charge based reimbursement. Again, this could cause confusion and concern to the patient.

Secondly, for Rural Health Clinics, the amount of coinsurance due from the patient is computed as 20% of total charges. The problem arises in that under charge based reimbursement, the amount of coinsurance due from the patient would be 20% of the Medicare's allowable charge, not the health center's actual charges. Given that the health center's charge is greater than the Medicare's allowable charge for a given service, the patient is paying a

higher coinsurance solely because of the reimbursement method chosen by the health center. Again, this could cause confusion and concern to the patient.

These issues are currently under investigation by HCFA. Until they are resolved, the best stance for the health center is to follow the guidelines of the intermediary. However, the health center must be prepared to discuss these issues with Medicare patients. Both health center management and office staff should understand these issues and be willing to explain them to Medicare patients when necessary.

4.) Coordination of benefits

a.) Medicaid

Medicare patients may also be covered by Medicaid. Medicaid benefits usually cover the 20% coinsurance and deductible. In the case where a patient is covered by both Medicare and Medicaid, Medicare is normally primary and Medicaid is secondary. Upon rendering services, the health center would file a claim first Medicare. After Medicare processes the claim, it is sent to Medicaid. Usually, this "crossover" to Medicaid is automatic if the patient's MA# is provided. If not, the health center must file the claim to Medicaid with Medicare's explanation of benefits attached.

b.) Medigap Policies

Medicare beneficiaries are not precluded from purchasing private health insurance, and many have purchased what are referred to as medigap policies. These policies are meant to be supplemental to Medicare coverage. The health center can bill the medigap carrier after it receives payment from Medicare; however, the total amount reimbursed to the heath center can never exceed Medicare's allowable amount for covered services. Some medigap policies such as those sold by Blue Cross/Blue Shield can also be billed automatically if the patient's policy number is indicated on the claim form.

c.) Medicare as secondary coverage

Traditionally, Medicare has always been the primary insurer. Today, however, it is not uncommon for a person to remain employed after the age of 65 and to continue health insurance coverage through his/her employer. In this case, Medicare is the secondary insurer. Medicare will not process a claim for services until it receives an EOB from the primary insurer. Those health centers which do not file claims to private carriers must obtain a copy of the EOB from the patient. C/MHC staff should explain this requirement to the patient at the time of service to facilitate the process.

5.) Cost Reports

Health centers which are reimbursed by Medicare on a cost basis (i.e. RHCs and FFHC's) are required to file cost reports to Medicare through their respective Medicare intermediary. In general, the process for completing cost reports and receiving cost based reimbursement can be summarized as follows.

- At the outset of its initial reporting period and at the beginning of each subsequent reporting period, the health center completes the cost report using estimated costs and number of visits, and files each of these reports with Medicare's intermediary.

- The intermediary computes an interim all-inclusive rate of reimbursement based upon the cost report data.

- The clinic is paid the all-inclusive rate for each covered visit by Medicare beneficiary regardless of the actual charges incurred during the visit.

- At the end of the reporting period, the clinic completes a final cost report using actual cost and visit data, and files the report with the intermediary.

- The intermediary computes total Medicare reimbursement for the period and computes amount due to/from the Medicare. The amount due to/from Medicare is equal to total Medicare reimbursement less interim payments less coinsurance and deductibles paid by Medicare patients during the period.

Specific information about RHC cost reports and FFHC cost reports is discussed below.

a.) Rural Health Clinics

1. Cost Report

Rural Health Clinics use form HCFA-222 to report cost and volume information. A copy of HCFA-22 with instructions is included in the appendices.

Form HCFA-222 includes a Statistical Data Worksheet and Worksheets 1, 2, and 3.

- The **Statistical Data Worksheet** provides general information about the RHC, such as name, address, legal structure, and names of providers.

- **Worksheet 1** is used to record the trial balance of expenses from the RHC's internal accounting records and to make any necessary adjustment and reclassification.

- **Worksheet 2** is used by the RHC to summarize visit volume and overhead cost incurred by the clinic which apply to rural health services.

- **Worksheet 3** is used by the intermediary to determine the interim all-inclusive rate of payment at the beginning of the reporting period and total Medicare reimbursement at the end of the reporting period.

Rural Health Clinics are required to complete the Statistical Data Worksheet and Worksheets 1 and 2. At the request of the RHC, the intermediary will complete Worksheet 3. However, it is highly recommended that the RHC complete Worksheet 3. By completing Worksheet 3 the RHC can project its own reimbursement rate. This information is valuable for budgeting purposes and projecting cash flow.

2. Reporting Requirements

- At the beginning of the reporting period, the RHC files the cost report based upon projected costs and volume data.
- At the end of the reporting period, the RHC files the cost report based upon actual costs and volume data.

The reporting period is specified by the RHC's fiscal intermediary. The reporting period may not coincide with the RHC's fiscal year.

The health center can request that the interim rate be adjusted during the reporting period if it experiences significant change in its cost of providing services.

b.) Federally Funded Health Centers

1. Cost Reports

FFHCs use form HCFA 242. HCFA 242 must be completed by all independent federally funded health centers reimbursed on a cost basis.

Form HCFA 242 includes a Statistical Data Worksheet and Worksheets 1, 2, 3 and 4.

- **Statistical Data Worksheet** is used to provide general information about the FFHC, for example clinic name and address, clinic number, source of federal funds, and name of physicians providing services.
- **Worksheet 1** provides for recording the trial balance of expense accounts from the FFHC's accounting books and records. The worksheet also provides for any necessary reclassification and adjustments to expenses.
- **Worksheet 2** is used to record information regarding full time equivalent staff and medical visits.
- **Worksheet 3** is used to summarize screening guidelines related to productivity standards, allowable direct costs, and staff.
- **Worksheet 4** is used to determine the rate of payment.

An FFHC must complete the Statistical Data Worksheet, Worksheet 1 and Worksheet 2. At the request of the FFHC, the intermediary will complete Worksheet 3 and Worksheet 4. However, FFHCs are strongly encouraged to

complete Worksheets 3 and 4. In doing so, the FFHC is able to compute a projected all-inclusive rate. This information is valuable for budgeting purposes and for projecting cash flow.

2. Reporting Requirements

FFHCs are required to file three cost reports per year:

- Budgeted (projected) annual report, which is due three months prior to the beginning of the reporting period.
- Six months actual report, which is due 60 days from the end of the six month period within the reporting period.
- Full year actual report, which is due within 90 days from the end of the reporting period.

The reporting period is a consecutive 12-month period and is established by the intermediary.

D. RECOMMENDATIONS FOR MAXIMIZING REIMBURSEMENT

1.) Selection of Appropriate Reimbursement Mode

A C/MHC should select the mode of reimbursement which provides it with the greatest reimbursement. The following points should be considered:

Eligibility. A C/MHC may be unable to select a certain mode of reimbursement because it does meet eligibility requirements. For example, even a rural C/MHC site without a halftime mid-level practitioner does not qualify for reimbursement under the Rural Health Act and, therefore, cannot be reimbursed under those guidelines.

System Requirements. Cost based reimbursement for both RHCs and FFHCs requires an accounting system capable of providing the information necessary to complete cost reports. A C/MHC should consider whether the investment necessary to improve the accounting system is exceeded by the projected increase in reimbursement.

Efficiency of operation. A C/MHC should consider the efficiency of its operations. Under the charge based mode any cost reductions resulting from more efficient operations can result in increased profits. The same is not true under cost based reimbursement, when reduced costs usually mean reduced reimbursement.

Assuming these issues have been accounted for, the health center should choose the reimbursement mode that provides the greatest total reimbursement from Medicare. This is determined by projecting reimbursement under each of the possible modes. Reimbursement under cost based reimbursement can be estimated using the respective cost reports; use HCFA 222 for RHC and HCFA 242 for FFHC. Projecting reimbursement under the charge based system requires

that the health center obtain prevailing rates for area. This can be done by requesting prevailing rates from the carrier or intermediary for the specific medical specialties employed at the health center. Projected reimbursement would be equal to projected volume by service multiplied by the lower of prevailing or actual charge.

2.) Maximizing reimbursement

In general, a health center managers can maximize reimbursement by understanding those variables which most significantly impact reimbursement. In this way, management, support staff, and providers can ensure that information regarding these variables is accurately reported, thereby maximizing the health center's potential Medicare reimbursement.

In addition, health center staff should develop a good working relationship with the Medicare intermediary or carrier. This relationship can be enhanced through the designation of a single staff member to be the Revenue (or Medicare) Specialist. The Revenue Specialist can coordinate communications with third parties, analyze C/MHC billing/collection activities and provide or coordinate the training of provider and support staff on reimbursement-related matters.

Some suggested tactics to maximize reimbursement under a particular reimbursement mode are outlined below.

Rural Health Clinics

- Maximize the allocation of costs to rural health services without exceeding the overall limit on the all-inclusive rate.
- Establish separate fees for non-rural health services and file claims for reimbursement under charge-based reimbursement.
- Maximize provider productivity through effective scheduling, efficient patient flow, compensation incentives, etc.

Federally Funded Health Centers

- Classify expenses as direct, i.e. non overhead expenses wherever possible. For example, make sure that the cost of printing encounter forms is included in medical supplies expense rather than office supplies expense. The importance of expense classification and allocation should be relayed to the staff person responsible for paying invoices and cataloging expenses.
- Maximize the number of physician visits.

Charge-Based Health Centers

- o Update fees using at least annually to keep profile in line with increasing costs.

- o Code claims in a manner which maximizes reimbursement to the health center. This includes using surgical codes correctly and properly relating all relevant diagnoses to procedures billed.

Regardless of the mode of reimbursement, its is recommended that one staff person be assigned the responsibility for Medicare reimbursement, and that the designated person receive on-going training relative to this area. Training sessions are provided by medical societies, intermediaries and carriers, and private consultants. As suggested above, an in-house Medicare Specialist will increase the likelihood: that claims are coded to maximize reimbursement, that denied claims are refiled on a timely basis, and that Medicare benefits are coordinated with other insurers. In addition, this person will serve as a patient advocate, that is someone who can explain Medicare benefits to patients.

E. ADDITIONAL RESOURCES AND CONTACTS

Rural Health Clinic Reimbursement

For certification as a Rural Health Clinic contact the respective State Agency. A list of State Agencies with addresses is included in the Appendix.

For questions regarding the filing of cost reports and other reimbursement matters contact the respective Medicare intermediary. A list of RHC Medicare Intermediaries is included in Table VI-1.

Federally Funded Health Center Reimbursement

For qualification as a FFHC, contact the respective HCFA Regional Office.

For questions concerning the filing of cost reports and other reimbursement matters contact Aetna Life and Casualty.

Charge Based Reimbursement

To become a participating provider contact respective carrier.

For questions regarding the filing of claims and other reimbursement matters contact the respective carrier.

Other sources of information

1. Provider Reimbursement Manual (HIM -15)

2. Title 42 of Code of Federal Regulations

3. Commerce Clearing House Topical Law Reports - Medicare and Medicaid Guide

APPENDICES

APPENDICES FOR CHAPTER V - MEDICARE REIMBURSEMENT

APPENDIX I	List of Medicare carriers for Part B
APPENDIX II	Collection Policies and Procedures
APPENDIX III	Sample collection letters
APPENDIX IV	List of FFHC rate limits by state
APPENDIX V	List of State Agencies for RHC certification
APPENDIX VI	Example of Questionnaire for FFHC qualification
APPENDIX VII	Example of an Intermediary's new provider questionnaire for FFHCs
APPENDIX VIII	RHC Cost Report - HCFA 222
APPENDIX IX	FFHC Cost Report - HCFA 242

APPENDIX I

LIST OF MEDICARE CARRIERS FOR PART B

Carriers for Part B. - The following list of carriers is reproduced from The Medicare Handbook, publication No. HCFA-10050. It is complete as of January 1989.

Beneficiaries entitled to Medicare under the railroad retirement system must send their medical insurance claims to The Travelers Insurance Compnay regional offices. Addresses of the regional offices are available at any railroad retirement office.

Alabama

Medicare
Blue Cross-Blue Shield of Alabama
P.O. Box C-140
Birmingham, Alabama 35283

Alaska

Medicare
Aetna Life & Casualty
200 S.W. Market Street
P.O. Box 1998
Portland, Oregon 97207

Arizona

Medicare
Aetna Life & Casualty
P.O. Box 37200
Phoenix, Arizona 85069

Arkansas

Medicare
Arkansas Blue Cross-Blue Shield
P.O. Box 1418
Little Rock, Arkansas 72203

California

Counties of Los Angeles, Orange, San Diego, Ventura, Imperial, San Luis Obispo, Santa Barbara

Medicare
Transamerica Occidental Life Insurance Co.
Box 50061
Upland, California 91785

Rest of State

Medicare Claims Department
Blue Shield of California
Chico, California 95976

Colorado

Medicare
Blue Shield of Colorado
700 Broadway
Denver, Colorado 80273

Connecticut

Medicare
The Travelers Insurance Co.
P.O. Box 5005
Wallingford, CT 06493

Delaware

Medicare
Pennsylvania Blue Shield
P.O. Box 65
Camp Hill, PA 17011

District of Columbia

Medicare
Pennsylvania Blue Shield
P.O. Box 100
Camp Hill, PA 17011

Florida

Medicare
Blue Shield of Florida, Inc.
P.O. Box 2525
Jacksonville, Florida 32231

Georgia

Medicare
Aetna Life & Casualty
P.O. Box 3018
Savannah, Georgia 31402

Hawaii

Medicare
Aetna Life & Casualty
P.O. Box 3947
Honolulu, Hawaii 96812

Idaho

Medicare
EQUICOR, Inc.
P.O. Box 8048
Boise, Idaho 83707

Illinois

Blue Cross & Blue Shield of Illinois
Medicare Claims
P.O. Box 4422
Marion, Illinois 62959

Indiana

Medicare Part B
Associated Ins. Co.
P.O. Box 7073
Indianapolis, Indiana 46207

Iowa

Medicare
Blue Shield of Iowa
636 Grand
Des Moines, Iowa 50309

Kansas

Counties of: Johnson, Wyandotte,

Medicare
Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Rest of State:

Medicare
Blue Shield of Kansas
P.O. Box 239
Topeka, Kansas 66601

Kentucky

Medicare-Part B
Blue Cross & Blue Shield of Kentucky
100 E. Vine Street
Lexington, Kentucky 40507

Louisiana

Blue Cross & Blue Shield of Louisiana
Medicare Administration
P.O. Box 95024
Baton Rouge, Louisiana 70895

Maine

Medicare
Blue Shield of
Massachusetts/Tri-State
P.O. Box 1010
Biddeford, Maine 04005

Maryland

Counties of: Montgomery,
Prince Georges

Medicare
Pennsylvania Blue Shield
P.O. Box 100
Camp Hill, PA 17011

Rest of State:

Maryland Blue Shield, Inc.
700 E. Joppa Road
Towson. Maryland 21204

Massachusetts

Medicare
Blue Shield of
Massachusetts, Inc.
55 Accord Park Drive
Rockland, MA 02371

Michigan

Medicare Part B
Michigan Blue Cross &
Blue Shield
P.O. Box 2201
Detroit, Michigan 48231

Minnesota

Counties of: Anoka, Dakota,
Filmore, Goodhue, Hennepin,
Houston, Olmstead, Ramsey,
Wabasha, Washington, Winona

Medicare
The Travelers Insurance Co.
8120 Penn Avenue, South
South Bloomington, MN 55431

Rest of State:

Medicare
Blue Shield of Minnesota
P.O. Box 64357
St. Paul, Minnesota 55164

Mississippi

Medicare
The Travelers Insurance Co.
P.O. Box 22545
Jackson, Mississippi 39225

Missouri

Counties of: Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Clair, Saline, Vernon, Worth

Medicare
Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Rest of State:

Medicare
General American Life Insurance, Co.
P.O. Box 505
St. Louis, Missouri 63166

Montana

Medicare
Blue Shield of Montana, Inc.
2501 Beltview
Helena, Montana 59604

Nebraska

Medicare Part B
Blue Cross & Blue Shield of Nebraska
P.O. Box 3106
Omaha, Nebraska 68103

Nevada

Medicare
Aetna Life & Casualty
P.O. Box 37230
Phoenix, Arizona 85069

New Hampshire

Medicare
Blue Shield of Massachusetts/ Tri-State
P.O. Box 1010
Biddeford, Maine 04005

New Jersey

Medicare
Pennsylvania Blue Shield
P.O. Box 400010
Harrisburg, PA 17140

New Mexico

Medicare
Aetna Life & Casualty
P.O. Box 25500
Oklahoma City, OK 73125

New York

Counties of: Bronx, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, New York, Orange, Putnam, Richmond, Rockland, Suffolk, Sullivan, Ulster, Westchester

Medicare
Empire Blue Cross & Blue Shield
P.O. Box 100
Murray Hill Station
Yorktown Heights, NY 10598

County of: Queens

Medicare
Group Health, Inc.
P.O. Box A966
Times Square Station
New York, New York 10036

Rest of State:

Medicare
Blue Shield of Western NY
P.O. Box 600
Binghamton, NY 13902-0600

North Carolina

EQUICOR, Inc.
P.O. Box 671
Nashville, Tennessee 37202

North Dakota

Medicare
Blue Shield of North Dakota
4510 13th Avenue, S.W.
Fargo, North Dakota 58121

Ohio

Medicare
Nationwide Mutual Insurance, Co.
P.O. Box 57
Columbus, Ohio 43216

Oklahoma

Medicare
Aetna Life & Casualty
701 N.W. 63rd St., Suite 300
Oklahoma City, Oklahoma 73116

Oregon

Medicare
Aetna Life & Casualty
200 S.W. Market Street
P.O. Box 1997
Portland, Oregon 97207

Pennsylvania

Medicare
Pennsylvania Blue Shield
Box 65
Camp Hill, PA 17011

Rhode Island

Medicare
Blue Shield of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

South Carolina

Medicare Part B
Blue Cross & Blue Shield
of South Carolina
Fontaine Rd., Business Center
300 Arbor Lake Dr., Suite 1300
Columbia, South Carolina 29223

South Dakota

Medicare Part B
Blue Shield of North Dakota
4510 13th Avenue, S.W.
Fargo, North Dakota 58121

Tennessee

Medicare
EQUICOR, Inc.
P.O. Box 1465
Nashville, Tennessee 37202

Texas

Medicare
Blue Cross & Blue Shield
of Texas, Inc.
P.O. Box 660031
Dallas, Texas 75266

Utah

Medicare
Blue Shield of Utah
P.O. Box 30269
2455 Parley's Way
Salt Lake City, Utah
84130-0269

Vermont

Medicare
Blue Shield of
Massachusetts/Tri-State
P.O. Box 1010
Biddeford, Maine 04005

Virginia

Counties of: Arlington,
Fairfax
City of: Alexandria, Falls
Church, Fairfax

Medicare
Pennsylvania Blue Shield
P.O. Box 100
Camp Hill, PA 17011

Rest of State:

Medicare
The Travelers Insurance Co.
P.O. Box 26463
Richmond, Virginia 23261

Washington

Medicare
Washington Physician Service
Mail to your local Medical
Service Bureau. If you do
not know who handles your
claim, mail to:

Medicare
Washington Physician Service
4th & Battery Bldg., 6th Fl.
2401 4th Avenue
Seattle, Washington 98121

West Virginia
Medicare
Nationwide Mutual Insurance, Inc.
P.O. Box 57
Columbus, Ohio 43216

Wisconsin
Medicare
Wisconsin Physicians' Service
Box 1787
Madison, Wisconsin 53701

Wyoming
Medicare
EQUICOR, Inc.
P.O. Box 628
102 Indian Hills Shpg. Center
Cheyenne, Wyoming 82003

American Samoa
Medicare
Hawaii Medical Services Assn.
818 Keeaumoku
Honolulu, Hawaii 96808

Guam
Medicare
Aetna Life & Casualty
P.O. Box 3947
Honolulu, Hawaii 96812

Northern Mariana Islands
Medicare
Aetna Life & Casualty
P.O. Box 3947
Honolulu, Hawaii 96812

Puerto Rico
Medicare
Seguros De Servicio De Salud De Puerto Rico
Call Box 71391
San Juan, Puerto Rico 00936

Virgin Islands
Medicare
Seguros De Servicio De Salud De Puerto Rico
Call Box 71391
San Juan, Puerto Rico 00936

APPENDIX II

COLLECTION POLICIES AND PROCEDURES

Criteria for allowable bad debts

1. The debt must be related to Medicare covered services and derived from Medicare deductible and coinsurance amounts deemed as uncollectible.

2. The Provider must be able to establish that reasonable collection efforts were made, i.e.,

   a. Collection effort must be similar to the effort the Provider puts forth to collect from a non-Medicare patient.

   b. Collection agencies may be used, but the agency cannot use or threaten to use court action. When a collection agency is used, the collected payments must be credited to the patient's account and the collection fee charged to the clinic's administrative expenses.

   c. If the bill remains unpaid 120 days from the date the bill is first mailed to the beneficiary, and reasonable and customary collection efforts have been made, the bill may then be deemed uncollectible.

   d. The clinic's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, telephone and personal contacts, etc.

Accounting Period for Bad Debt

1. Uncollectible bad debts for deductibles and coinsurance are recognized as allowable bad debts in the reporting period that they are determined to be worthless.

Examples Date Billed	Determined to be Worthless 121 Days After First Billed	Fiscal Year End	Allowable as Bad Debt in Fiscal Period Ending
06/01/80	09/29/80	06/30	06/30/81
07/01/80	10/29/80	06/30	06/30/81
12/01/80	03/31/81	12/31	12/31/81
06/01/81	09/29/81	12/31	12/31/81
10/01/81	01/29/82	12/31	12/31/82

Calculation of Net Bad Debts

1. Net bad debts are calculated on HCFA form 222 Worksheet 2, Part E. Lines:

   W/S 2
   Lines:
   1. Total deductible and coinsurance billed to patient for the cost reporting period.

   2. Total deductible and coinsurance received from patients.

   3. Bad debts determined by subtracting Line 2 from Line 1.

   4. Enter any bad debt recovery of previous amounts written off as bad debts.

   5. Net bad debt, Line 3 less Line 4.

Reimbursement of Medicare Bad Debts

1. Submit with cost report the following substantiation:

   a. Statement that reasonable collection efforts have been made in accordance with Medicare regulations (HIM-15, Sec. 300). State what efforts have been made to collect bad debts.

   b. The following patient information for each bad debt.

      1. Medicare beneficiary number
      2. Beneficiary's name
      3. Date of visit
      4. Charge for the visit
      5. Deductible and coinsurance amounts
      6. Amount of deductible and coinsurance determined to be worthless in accordance with regulations (HIM-15, Sec. 300)

      Support for bad debts can be submitted in the form of a bad debt log. A photocopy of the patient ledger card may be submitted provided the above information for each bad debt is clearly displayed.

      Following on the next page is a sample format of a "Medicare Bad Debt Log." The information needed for columns 1 through 6 of the log should be obtained directly from the Medicare Remittance Advice sheets.

APPENDIX III

SAMPLE COLLECTION LETTERS

NAME_____

ADDRESS_____

_____

_____

BILLING DATE_____

Dear Patient,

The following is a billing for your recent services at Health Services in . This is the portion you owe for your yearly deductible or the co-insurance you owe after Medicare has paid their portion. Please compare this statement to the Explanation of Medicare Benefits you should have received from Aetna Insurance Company for this same date of service.

Thank you for your Payment of: $ _____

If you have any questions, please call our Medicare Billing Department.

BALANCE FROM YOUR PREVIOUS STATEMENT: $ _____

SERVICE DATES	DESCRIPTION OF SERVICES	TOTAL CHARGES	AMOUNT PATIENT OWES 20%	Deductible

TOTAL DUE FROM PATIENT: $_____

Description Code of Services Rendered

OV - Office Visit	Inj - injection	Lab - Laboratory Work
HC - House Call	Sup - Supplies	NHV - Nursing Home Visit
OB - Obstetrics	MCR - Medicare	Hosp. Admit - Admission into Hospital
ROA - Rec'd on Acct.	MCD - Medicaid	Emer. OV - Emergency Office Visit
RX - Medicines	lac - laceration repair	Surg - Minor Surgery (in office)
Stmnt - Statement	filed - The date that Medicare or Medicaid was billed	

Dear_____

We have recently sent you two statements showing the amount you owe after Medicare has paid their portion of your charges.

We have not yet received your payment. We realize that it is often very difficult to pay for medical care and medications. If a financial problem is preventing you from paying on your account, please tell us.

We have a program available to help you, and we will be happy to explain it to you in greater detail. We will hold all information you give us in strict confidence and talk with you in a private office. Please do not hesitate to let us know if you need this assistance.

We will be looking forward to hearing from you soon.

Sincerely,

MEDICARE 90 DAY

Dear_____

We have recently sent you two statements showing the amount you owe after Medicare has paid their portion of your charges.

We have not yet received your payment. We realize that it is often very difficult to pay for medical care and medications. If a financial problem is preventing you from paying on your account, please tell us.

We have a program available to help you, and we will be happy to explain it to you in greater detail. We will hold all information you give us in strict confidence and talk with you in a private office. Please do not hesitate to let us know if you need this assistance.

We will be looking forward to hearing from you soon.

Sincerely,

MEDICARE 120 DAY

Dear_____

We have recently been corresponding with you regarding your past-due account. We sent you an itemized statement showing how much you owe after Medicare paid their portion of your charges.

Then we sent you a second statement showing the amount due, with a reminder of the past-due status of your account.

Last month, we grew more concerned about you, and sent you a letter asking if you need financial assistance, and you still failed to respond to us.

We are at a loss as to why you continue to ignore our statements. We assume you have received them since they have not been returned to us by the Post Office.

Please take a few moments now to write out a check and mail us the amount shown due on the attached statement or give us a call and explain the problem to us.

If we have not heard from you within the next 14 days, we will be forced to process this account as a bad debt.

Sincerely,

APPENDIX IV

LIST OF FFHC RATE LIMITS BY STATE

1990

Prospective Limitations by State

Region I Boston	In-House With CBC*	Contracted Lab Without CBC*
Connecticut	71	62
Massachusetts	94	81
New Hampshire	52	40
Rhode Island	75	62
Region II New York		
New Jersey	70	61
New York	82	71
Puerto Rico	52	44
Region III Philadelphia		
Delaware	64	49
District of Columbia	79	67
Maryland	64	52
Pennsylvania	82	72
Virginia	64	52
West Virginia	63	52
Region IV Atlanta		
Alabama	68	59
Florida	88	76
Georgia	66	55
Kentucky	64	52
Mississippi	56	43
North Carolina	68	60
South Carolina	59	48
Tennessee	55	44
Region V Chicago		
Illinois	80	69
Indiana	70	59
Michigan	70	60
Minnesota	76	55
Ohio	68	58
Wisconsin	70	52

Prospective Limitations by State (cont.)

Region VI Dallas	In-House With CBC*	Contracted Lab Without CBC*
Arkansas	60	44
Louisiana	69	51
New Mexico	63	50
Oklahoma	69	51
Texas	75	64
Region VII Kansas City		
Iowa	74	60
Kansas	73	62
Missouri	78	67
Nebraska	63	51
Region VIII Denver		
Colorado	63	52
Montana	71	57
North Dakota	61	49
South Dakota	58	49
Utah	62	51
Wyoming	69	49
Region IX San Francisco		
Arizona	82	67
California	94	78
Hawaii	76	59
Nevada	96	76
Region X Seattle		
Idaho	71	59
Oregon	81	62
Washington	70	62

*CBC-Complete Blood Count Services

APPENDIX V

LIST OF STATE AGENCIES FOR RHC CERTIFICATION

STATE AGENCIES CERTIFYING RURAL HEALTH CLINICS

Alabama

Director, State Dept. of Public Health
Bureau of Licensure & Certification
654 State Office Building
Montgomery, AL 36104

Alaska

Dept. of Health & Social Services
Certification & Licensing Section
Pouch H 06 G
Juneau, AK 99811

Arizona

Bureau of Medical Facilities
Arizona Dept. of Health Facilities
1740 West Adams Street, Room 309
Phoenix, AZ 85007

Arkansas

Director, Div. of Hospitals
State Health Building
State Capital Grounds
Little Rock, AR 72201

California

Chief, Bureau of Health Facilities
Licensure & Certification
State Dept. of Public Health
Room 461, Office Building 9
744 P Street
Sacramento, CA 95814

Colorado

Director, Hospital & Nursing
Homes Section
Colorado Dept. of Public Health
4210 E. 11th Avenue
Denver, Colorado 80220

Connecticut

Commissioner of Health
State Dept. of Health
79 Elm Street
Hartford, CT 06115

Delaware

Office of Health Facilities
Licensing and Certification
2634 Kirkwood Highway
Newark, DE 19711

District of Columbia

Chief, Licensing & Certification Div.
Dept. of Human Resources
1406 L Street, N.W., 2nd Floor
Washington, D.C. 20005

Florida

Chief, Bureau of Health Facilities
Health Program Office
320 Riverside Avenue
P.O. Box 210
Jacksonville, FL 32204

Georgia

Standards & Licensure Unit
Ponce De Leon Office Park
618 Ponce De Leon Ave., N.E.
Atlanta, Georgia 30308

Guam

Director of Public Health Services
Government of Guam
P.O. Box 2816
Agana, Guam 96910

Hawaii

Director of Health
Hawaii Dept. of Health
P.O. Box 3378
Honolulu, Hawaii 96801

Idaho

Chief, Bureau of Health Care Services
Idaho Dept. of Health & Welfare
Statehouse
Boise, Idaho 83720

Illinois

Division of Health Facilities
Federal Program
Dept. of Public Health
525 W. Jefferson Street
Springfield, IL 62761

Indiana

Director, Div. of Medical Care
Administration
1330 W. Michigan Street
Indianapolis, IN 46206

Iowa

Commissioner
State Dept. of Health
Des Moines, Iowa 50319

Kansas

Kansas State Dept. of Health
and Environment
Medical Facilities Certification
Building 740, 2nd Floor
Topeka, Kansas 66620

Kentucky

Div. of Licensure & Regulations (MCS)
Dept. of Human Resources
Human Resources Building
4th Floor, East Wing
Frankfort, KY 40601

Louisiana

Louisiana Health & Human Resources Admin.
Div. of Mgmt. Licensing Sect.
333 Laurel Street
Baton Rouge, LA 70821

Maine

Department of Human Services
Division of Hospitals Services
99 Western Avenue
Augusta, Maine 04330

Maryland

Dept. of Health and Mental Hygiene
Div. of Lic. & Cert. Medicare Unit
201 W. Preston Street
O'Conner Building, 3rd Floor
Baltimore, Maryland 21201

Massachusetts

Dept. of Public Health
Institute of Laboratories
80 Boylston Street
Boston, MA 02116

Michigan

Chief, Michigan Dept. of Public Health
3500 North Logan Street
Lansing, Michigan 48914

Minnesota

Licensing & Certification Service
State Dept. of Health
State Board of Health Bldg.
Minneapolis, MN 55440

Mississippi

Health Facilities Certification
Felix J. Underwood State Board of Health
P.O. Box 1700
Jackson, MS 39205

Missouri

Director of Health
Section of Hospital & Technical Services
State Office
Jefferson City, MO 65101

Montana

Div. of Hospital & Medical Facilities
State Dept. of Health
Cogswell Building
Helena, MT 59601

Nebraska

State of Nebraska Dept. of Health
Division of Standards
301 Centennial Mall South
3rd Floor
Lincoln, Nebraska 68509

Nevada

Medicare Certification Section
Bureau of Health Facilities
State Health Division
505 East King Street
Carson City, Nevada 89710

New Hampshire

Director, Bureau of Health Facilities
Administration
Division of Public Health
61 S. Spring St.
Concord, NH 03301

New Jersey

Division of Health Facilities
Evaluation
New Jersey State Dept. of Health
501 John Fitch Way
Trenton, NJ 08611

New Mexico

Chief, Federal Program Certification
Section
Health and Social Services Dept.
408 Galisteo Street
P.O. Box 2348
Santa Fe, NM 87501

New York

Medical Program Coordinator
New York State Dept. of Health
ESP-Tower, 10th Floor, Swann St.
Albany, NY 12237

North Carolina

Chief, Dept. of Human Resources
Medicare-Medicaid Licensing Section
1330 St. Marys St.
P.O. Box 12200
Raleigh, NC 27605

North Dakota

Division of Health Facilities
State Dept. of Health
1200 Missouri Ave., Room 302
Bismarck, ND 58505

Ohio

Medicare
Ohio Dept. of Health
450 E. Town
Columbus, Ohio 43215

Oklahoma

Licensure & Certification-Medicare
Oklahoma State Dept. of Health
Northeast 10th & Stonewall Streets
Oklahoma City, Oklahoma 73105

Oregon

Director, Health Facilities
Licensing & Certification
State Board of Health
1400 South West Fifth Avenue
Portland, Oregon 97201

Pennsylvania

Admin., Officer, Medicare Cert.
Pennsylvania Dept. of Health
Health and Welfare Building, Room 1008
Harrisburg, PA 17120

Puerto Rico

Medicare Coordinator
Office of Certification & Licensure
Road #2
Bayamon, PR 00619

Rhode Island

Chief, Licensure & Construction
Rhode Island Dept. of Health
75 Davis Street
Providence, RI 02908

American Samoa

Hospital Administrator
Tropical Medical Center
Pago Pago, American Samoa 96920

South Carolina

Div. of Licensure & Certification
South Carolina Dept. of Health &
Environmental Control
2600 Bull Street
Columbia, SC 29201

South Dakota

Director, Resource Development Program
South Dakota Dept. of Health
Joe Foss Bldg.
Pierre, SD 57501

Tennessee

Director, Div. of Certification & Licensure
490 Capitol Hill Building, 4th Floor
Nashville, TN 37219

Texas

Licensure & Certification Programs
Texas Dept. of Health Resources
1100 W. 49th Street
Austin, Texas 78756

Utah

Director, Med. Care Service
State Division of Health
Health Insurance Benefits Section
44 Medical Drive
Salt Lake City, Utah 84113

Vermont

Chief, Medical Care Facilities
Vermont Dept. of Health
60 Main Street
Burlington, Vermont 05401

Virginia

Asst. Dir. Medical Certification Services
Med-Nursing Facility
State Dept. of Health
109 Governor Street
James Madison Building
Richmond, VA 23219

Virgin Islands

Commissioner of Health
State Dept. of Health
Charlotte Amalie
St. Thomas, VI 00801

Washington

Chief, Office of Personal Health Services
Dept. of Social & Health Services
Airport Building 12
Mailstop LM-11
Olympia, WA 98504

West Virginia

Director, Health Insurance Benefit Unit
State Dept. of Health
601 Morris St. 3rd Floor
Charleston, WV 25301

Wisconsin

Bureau of Health Facilities and Services
Division of Health
1 W. Wilson St., Room B-337
Madison, WI 53702

Wyoming

Medical Facilities Services
State Dept. of Health & Medical Services
Hathaway Bldg., 4th Floor
Cheyenne, WY 82002

APPENDIX VI

EXAMPLE OF QUESTIONNAIRE FOR FFHC QUALIFICATION

Paul Radford
Health Care Financing Administration
101 Marietta Tower, Suite 702
Atlanta, Georgia 30323
Phone: (404) 331-2237

(Please answer all questions fully)

ELIGIBILITY QUESTIONNAIRE FOR FEDERALLY FUNDED HEALTH CENTERS

1. Name, address and telephone number of facility providing the health services.

2. Name and address of Federal agency providing the grant.

3. Project number, title of project (the official grantee held accountable for the expenditures of the grant fund).

4. Please list the hours and days per week during which the Center provides health services.

5. Is a physician(s) on the premises and available at all the times shown above to render medical (rather than administrative) services.

YES NO

5A. List the name(s), social security number(s) and hours worked of each full-time physician employed at the center. (Specify which patient care site the physician works.) This information may be shown on your letterhead stationary as an addendum to this questionnaire.

6. If question # 5 is answered "NO", please itemize the types of medical services rendered during those times when a physician is not on the premises.

7. Approximately how many patients are seen at the clinic during a month?

7A. Of this number how many are Medicare beneficiaries?

8. Does the Center currently receive Medicare reimbursement?

YES NO

If "YES", what Medicare office processes your bills?

9. Does the Center customarily seek reimbursement from public and private third party cources as well as from the patient's own resources?

YES NO

10. Will the Center accept the Medicare payment for the covered services it provides Medicare beneficiaries as payment in full except for the deductible and coinsurance amounts?

YES NO

11. Does the health center have an accounting system established?

YES NO

12. Is there an accountant on staff?

YES NO

13. Are the Center's financial records maintained in sufficient detail to permit the filing of a Medicare cost report on an annual and semi-annual basis.

YES NO

14. Is your health center subject to the same board of governors and bylaws of any hospital?

YES NO

If "YES", what hospital is this?

15. Are the health center and the buildings of any hospital owned by the same party?

YES NO

If "YES", what hospital?

Are the operated under common management?

YES NO

16. Is there an arrangement between a hospital and the health center for the sharing of incomes or expenses or earnings?

YES NO

If "YES",what hospital?

17. Who owns the health center's medical records, and where are they kept?

18. Is the facility licensed as part of a hospital?

YES NO

If "YES", what hospital?

Is the facility accredited as part of a hospital? If "YES", what hospital?

N/A

YES NO

19. Are the health center's physicians also staff members of a hospital that was mentioned in any previous question?

YES NO

If "YES", what hospital?

20. Do the health center and a hospital share certain facilities, for example, laboratory and x-ray services?

YES NO

If "YES, what hospital?

21. Are health center patients who need hospitalization ordinarily hospitalized in any hospital mentioned in any of the preceeding questions?

YES NO

If "YES:, what hospital?

22. Is the health center located in a hospital or in the same complex of buildings as any hospital?

YES NO

If so, what hospital?

23. Is the health center held out to the public as part of a hospital?

YES NO

If "YES", what hospital?

24. Are paramedical personnel frequently exchanged between the health center and a hospital?

YES NO

If "YES, what hospital?

25. Are the different sections of the health center integrated with the corresponding inpatient services of a hospital?

YES NO

If "YES", what hospital?

26. Does the health center have the responsiblility for the followup of designated discharge hospital patients of any hospital?

YES NO

If "YES", what hospital?

27. Are the Health center's medical records integrated with the patient's overall records of any hospital?

YES NO

If "YES", what hospital?

28. Does your health center employ Nurse Practitioners or Physicians' Assistants?

YES NO

Name of facility _____

Address of Facility _____

_____ 3/14/89

(Signature and Title of Authorized Official) (Date)

APPENDIX VII

EXAMPLE OF AN INTERMEDIARY'S NEW PROVIDER QUESTIONNAIRE FOR FFHCS

REVIEW OF NEW PROVIDER'S FISCAL RECORD

PROVIDER NAME: _____

DATE OF CONTACT: _____

PERSON CONTACTED: _____

TELEPHONE NUMBER: _____

2404.2 EXAMINATION OF PERTINENT DATA AND INFORMATION

YES NO

A. LIABILITY FOR HEALTH INSURANCE PROGRAM PAYMENTS

1. WHAT IS THE PROPER LEGAL NAME AND ADDRESS OF NEW PROVIDER?

_____

_____

_____

2. HAS THE PROVIDER TAKEN OVER THE OPERATION OF AN INSTITUTION FROM A PROVIDER THAT, AS A RESULT OF TRANSFER, LEASE, SALE, OR OTHER ACTION, HAS TERMINATED PARTICIPATION IN THE PROGRAM? IF YES, PLEASE EXPLAIN.

_____

_____

_____

COUNTY: _____

WHAT IS YOUR STARTING DATE OF OPERATIONS? _____

B. TYPE OF ORHANIZATION

1. NON-PROFIT - HAS AN INTERNAL REVENUE SERVICE CERTIFICATE OF NONPROFIT STATUS UNDER SECTION 501 (c) OF THE INTERNAL REVENUE ACT OF 1954 BEEN ISSUED?

2. ARE YOU A NON-PROPIETARY ORGANIZATION?

YES NO

3. PROPRIETARY ORGAINIZATION - IS THE ORGANIZATION A:

   A. SOLE PROPRIETORSHIP
   B. PARTNERSHIP
   C. CORPORATION

C. LEASES

1. IS THE REAL PROPERTY (BUILDING, SPACE, OR LAND) OCCUPIED OWNED OR LEASED BY THE PROVIDER? ANSWER: _____

2. IF ANY PERSONAL PROPERTY IS LEASED, DETERMINE IF THERE IS A LEASE PURCHASE AGREEMENT.

D. PROVIDER - BASED PHYSICIANS

DO YOU HAVE A MEDICAL DIRECTOR?

IS HE/SHE COMPENSATED?

PLEASE INDICATE HOW MUCH?

E. FIXED ASSET RECORDS

1. DETERMINE METHOD OF DEPRECIATION

-STRAIGHT - LINE

-DECLINING BALANCES

-SUM OF THE YEARS DIGITS

2. WHAT IS THE CAPITALIZATION POLICY?

---

3. IS DEPRECIATION CLAIMED DURING THE YEAR OF ACQUISITION?

IF SO, WHAT IS THE POLICY?

F. PREPARATION OF COST REPORTS YES NO

HAS THE PROVIDER EVER PREPARED ANY TYPE OF COST REPORTS?

HAS THE PROVIDER'S ACCOUNTANT EVER PREPARED ANY TYPE OF COST REPORTS?

G. CHAIN ORGAINIZATION

IS THE PROVIDER A MEMBER OF A CHAIN ORGAINIZATION?

IF YES, LIST THE NAME OF THE ORGAINIZATION, THE ADDRESS OF THE HOME-OFFICE, NAME OF THE HOME-OFFICE INTERMEDIARY, AND THE LOCATION OF RECORDS PERTAINING TO HOME OFFICE COSTS.

H. REQUEST FOR MULTIPLE-FACILITY STATUS

IS THE PROVIDER A COMPONENT OF SEVERAL PROVIDERS?

IF YES, DOES THE PROVIDER HAVE THE CAPABILITIES TO SEPARATE COST AND REVENUES BETWEEN VARIOUS ENTITIES OF THE FACILITY?

I. PROVIDERS ACCOUNTING FIRM

OBTAIN THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE PROVIDER'S INDEPENDENT ACCOUNTANT.

J. INDICATE THE PROVIDERS FISCAL YEAR END

K. FEDERAL I.D. #

L. GENERAL COMMENTS

M. RECOMMEDATION

PREPARED BY _____

DATE _____

APPENDIX VIII

RHC COST REPORT - HCFA 222

INITIAL SETTLEMENT CALCULATION SHEET

CHC Name _____

CHC No. _____

Cost Report Period From _____ To _____

	Mental Health		Medical	
Total Medicare Covered Encounters	#	#	#	#
Lower of Cost or State Limit * Per Encounter (Worksheet 4, Part C, Line 7 or 8)	$_____	$_____	$_____	$_____
Cost of covered services	$	$	$	$
Mental Health Limitation	.625	.625	_____	_____
Total cost of covered services	$	$	$	$
Combined total cost				$
Less deductible				_____
Net cost				$
80% of net cost - reimbursable to provider				$
Less 1% sequestration adjustment x .01 / 12 ( )				$ _____
Net reimbursable cost				$
Less interim payments				_____
Balance due provider/medicare (Brackets indicate overpayments)				$ _____

*The encounter rate payment limitation for the State of _____ is $ for

INDEPENDENT RURAL HEALTH CLINIC WORKSHEETS FOR FORM HCFA-222

(PLEASE READ CAREFULLY BEFORE COMPLETING FORM)

Use of Worksheets

These forms must be used by all independent Rural Health Clinics (RHC's). These forms are required for the determination of Medicare reimbursement for rural health clinic services under Subpart X (42 CFR Part 405) of the Medicare regulations.

A RHC must complete the Statistical Data Worksheet, Worksheet 1 and Worksheet 2. These worksheets provide general information and summarize visits furnished and actual (or estimated) costs of rural health clinic services. At the RHC's option, the RHC's fiscal intermediary will complete Worksheet 3 to determine the all-inclusive rate and the amount of the payment reconciliation. However, HCFA encourages the RHC to complete all worksheets and to submit them to the fiscal intermediary. By completing all worksheets, the RHC can determine its own interim rate and its total reimbursement when preparing the end of year actual report.

A RHC must complete all applicable items on the Statistical Data Worksheets 1 and 2. For its initial reporting period, the clinic will complete these reports with estimates of costs and visits and other information required by the reports. The intermediary will use the estimates to determine an interim rate of payment for the clinic. Following the end of the clinic's reporting period, the clinic is required to submit its worksheets using data based on its actual experience for the reporting period. This information will be used by the intermediary as the basis for determining the total Medicare reimbursement due the RHC for rural health clinic services furnished Medicare beneficiaries.

STATISTICAL DATA

Item 1 — Clinic Name and Address

Enter here the full name and address of the RHC.

Item 2 — Clinic Number

Enter the RHC identification number that was provided by HCFA when clinic entered program.

Item 3 — Reporting Period

Enter on the appropriate lines the inclusive dates covered by these worksheets. A reporting period is a period of 12 consecutive months specified by the intermediary as the period for which a clinic must report its costs and utilization. The first and last reporting periods may be less than 12 months.

Item 4 — Type of Control

Check the type of control or auspices under which the clinic is conducted. Do not show here the source of any grants the clinic may be receiving.

Item 5 — Ownership

Enter the name of the person(s) or organization(s) which is the legal owner of the clinic. If the RHC is a proprietary organization, enter the name(s) of the individual(s) or organization(s) owning the clinic or common stock of the clinic.

Item 6 — Related Organizations

List all clinics, providers of services (hospitals, skilled nursing facilities, home health agencies) suppliers or other entities that are owned, or related through common ownership or control, to the individual or entity listed in Item 5.

Item 7 — Physicians Providing Services to RHC

List all physicians furnishing services at the RHC or under agreements and their Medicare billing numbers.

Item 8 — Supervisory Physicians

Enter the name of all supervisory physicians and the number of hours spent in supervision.

Item 9 — Certification Statement

The certification statement must be prepared and signed after the worksheets have been entirely completed. The individual signing this statement must be an officer or other authorized responsible person.

WORKSHEETS

WORKSHEET 1 — RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSE

Worksheet 1 is used to record the trial balance of expense accounts from the clinic's accounting books and records (for end of year cost reports, the clinic should use its actual trial balance. For budgeted reports, an estimated trial balance should be used). This worksheet also provides for any necessary reclassificatons and adjustments to these accounts.

The cost centers listed on the worksheet are listed in the order in which the cost data is used on worksheets 2 and 3 and should facilitate the transfer of this data to these worksheets. Not all of the listed cost centers will apply to each clinic. For example, a clinic might not employ laboratory technicians and would not, in that case, complete line 6. The worksheet also provides blank lines for clinic cost centers in addition to those listed in the form.

If the cost elements of a particular cost center are maintained separately on the clinic's books, a supporting worksheet reconciling the cost per the accounting books and records to those on the worksheet must be completed.

COLUMNS 1 THROUGH 3 — TRIAL BALANCE OF EXPENSES

For actual cost reports, the expenses listed in these colums must be in accordance with the clinic's accounting books and records.

Enter on the appropriate lines in column 1 through 3 the total expenses incurred during the reporting period. The expenses must be detailed Compensation (column 1), and Other (column 2). The sum of columns 1 and 2 must equal column 3. Any needed reclassifications and adjustments must be recorded in columns 4 and 6, as appropriate.

COLUMN 4 — RECLASSIFICATION

Enter in this column any reclassification among the cost centers experience in column 3 which are needed to effect proper cost allocation. Reclassifications are used in in-

stances in which the expenses applicable to more than one of the cost centers listed on the worksheet are maintained in the clinic's accounting books and records in one cost center. For example, if a physician performs some administrative duties, the appropriate portion of his compensation, and applicable payroll taxes and fringe benefits, would need to be reclassified from "Clinic Health Care Staff Cost" to "Clinic Overhead Administration Cost." That is, it would have to be included under "Clinc Overhead" rather than "Clinic Health Care Staff Cost."

All reclassifications reflected in this column must be explained on a supporting schedule prepared by the clinic.

This supporting schedule must provide for an explanation of the reclassification entry and show the proper amount allocated to each of the affected cost centers. Reduction to expenses should be shown in brackets ( ). The net total of the supporting schedule and column 4 of the worksheet must equal zero.

COLUMN 5 — RECLASSIFIED TRIAL BALANCE

This column is used to combine the amounts entered in column 3 with the amount of the reclassification entered in column 4. The net balance for each line is entered in column 5. The total of column 5 on line 72, must equal the total of column 3 on line 72.

COLUMN 6 — ADJUSTMENTS

Enter in this column the amount of any adjustments to the clinic's reclassified expenses. Adjustments are required to adjust (increase or decrease) actual expenses in accordance with the Medicare rules on allowable costs. Examples of situations in which adjustments to expenses would be required are:

1. the clinic has transactions with a related organization;
2. the clinic receives restricted grants and gifts;
3. the clinic depreciates assets on a basis other than an acceptable basis recognized by Medicare;
4. the clinic has a practitioner assigned by the National Health Service Corps;
5. the clinic receives an allocation of cost from a home office.
6. the clinic administered pneumococcal vaccine.

All adjustments reflected in column 6 must be detailed on a supporting schedule prepared by the clinic. The schedule must provide for a description of the adjustment, basis of adjustment (cost or amount received, if cost can not be determined) and amount to affected cost center(s). Reduction to expenses are shown in brackets ( ).

The cost and administration of pneumococcal vaccine to Medicare beneficiaries are 100 percent reimbursable by Medicare. To determine Medicare cost, adjustments are required for health care staff costs and medical supplies. Health care staff costs (line 13) should be reduced by the estimated percentage of time involved in pneumococcal vaccine injections multiplied by the amount of compensation. The cost of medical supplies (line 18), should be reduced by the cost of the vaccine. The sum of the adjustments for pneumococcal vaccine health care staff cost (col. 6, line 13) and medical supplies (col. 6, line 18) should be divided by the sum of the total indirect cost (col. 7, line 27) and pneumococcal vacine adjustments from line 13 and 18 of column 6. Multiply this amount by the total overhead (col. 5, line 54) to determine the overhead adjustment for pneumococcal vaccine. Transfer the sum of the adjustments for pneumococcal vaccine in column 6, lines 13, 18 and 54 to Worksheet 3, line B7.

COLUMN 7 — NET EXPENSES

This column is used to combine the reclassified trial balance in column 5 with the amounts of the adjustments shown in column 6. The amounts in column 7 are transferred to the appropriate lines in worksheets 2 and 3.

LINE DESCRIPTIONS

Lines 1 - 13 Clinic Health Care Staff Costs

Enter the costs of the clinic's health care staff on the appropriate line by type of staff.

Line 14 Physician Services Under Agreement

Enter the cost of physicians' medical services furnished under agreement. The net expense in column 7 of line 14 is transferred to line A5 of worksheet 2.

Line 15 Physician Supervision

Enter on this line the expenses of physician supervisory services, if furnished under agreements.

Line 17 - 25 Other Health Care Costs

Enter on these lines the expenses of other health care costs. If the clinic has cost centers in addition to those listed, lines 22 through 24 or supporting schedule may be used.

Line 27 Total Cost of RHC Services (Other Than Overhead)

Line 27 totals the cost (other than overhead) for rural health clinic services. Transfer this amount to line B1 of worksheet 2

Lines 30-41 Clinic Facility Costs

Enter on these lines the expenses related to the clinic's facility.

Line 42-52 Clinic Administration

Enter on these lines the expenses related to the administration and management of the clinic.

Line 54 Total Clinic Overhead

Line 54 is the sum of line 41 and 52. Transfer the total amount in column 7 to line B5 of worksheet 2.

Lines 56-64 Cost Incurred for Other than Rural Health Clinic Services.

Enter on these lines the cost centers applicable to services other than rural health clinic services (excluding overhead). Additional cost centers may be added on lines 61-63 or on a separate schedule. Transfer the cost expense in column 7 on line 64 to line B2 of worksheet 2.

Lines 66-70 Non-Reimbursable Costs

Enter in these lines the cost of services that are not reimbursable under Medicare.

Line 72 Total

Line 72 is the total cost of the clinic and is the sum of lines 27, 54, 64, and 70.

WORKSHEET 2 — VISITS AND OVERHEAD FOR RURAL HEALTH CLINIC SERVICES

General

Worksheet 2 is used by the RHC to summarize: 1) The visits actually furnished (or anticipated) by the clinic's health care staff and by physicians under agreements with the clinic;

and 2) the overhead costs incurred by the clinic which apply to rural health clinic services.

PART A — VISITS AND PRODUCTIVITY

Part A is used by the clinic to summarize the number of clinic visits furnished by the health care staff and to calculate the number of visits to be used in the rate determination in accordance with productivity standards established by the Health Care Financing Administration.

Lines 1 through 5 of Part A list the types of practitioners (positions) for whom clinic visits must be counted and reported.

Column 1, record the number of all FTE personnel in each of the applicable staff positions in clinic practice.

Column 2, record the total visits actually furnished to all patients by all personnel in each of the applicable staff positions in the reporting period. Visits are counted in accordance with 42 CFR 405.2401(b)(18).

Column 3 lists the visits required by productivity standards.

Column 4 is the minimum number of clinic visits the personnel in each staff position are expected to furnish. It is the product of column 1 and column 3.

Column 5, enter the greater of the visits in column 2 or column 4. Intermediaries have the authority to waive the productivity guideline in cases where a clinic has demonstrated reasonable justification for not meeting the standard. In such cases the intermediary could set any number of visits as reasonable, not just the clinic's actual visits, if an exception is granted. For example, if the guideline number is 4200 visits and the clinic has only furnished 1000 visits, the intermediary need not accept the 1000 visits as reasonable, but could permit 2500 visits to be used in the calculation.

Line 4 is used to total columns 2 and 5.

Line 5 is used by the clinic to record the number of visits furnished to clinic patients by physicians under agreement with the clinic. "Physicians' services under agreements" with the clinic means: (1) All medical services performed at the clinic site by a physician who is not the owner or an employee of the clinic; and (2) Medical services performed at a location other than the clinic site by such a physician for which the physician is compensated by the clinic. While all physician services at the clinic site are included in rural health clinic services, physician services furnished in other locations by physicians who are not on the full-time staff of the clinic are reimbursable to the clinic only if the clinic's agreement with the physician provides for compensation for such services.

PART B — DETERMINATION OF COST APPLICABLE TO RURAL HEALTH CLINIC SERVICES

Part B is used to determine the amount of clinic overhead cost applicable to rural health clinic services.

Line 1, enter the cost of RHC services other than overhead, from line 27 of Worksheet 1.

Line 2, enter the cost of services, other than RHC services excluding overhead, from lines 64 and 70 of Worksheet 1.

Line 3, enter the cost of all services,excluding overhead. It is the sum of lines 1 and 2.

Line 4 is the percentage of services other than RHC services.

This percentage is determined by dividing line 2 (cost of services other than RHC services), by line 3 (the cost of all services, excluding overhead).

Line 5, enter the total overhead costs incurred from line 54 of Worksheet 1. It is the sum of clinic facility costs and clinic administrative costs.

Line 6, enter the overhead applicable to services other than rural health clinic services. It is determined by multiplying line 5 (total overhead) by line 4 (the percentage of services other than rural health services furnished by the clinic).

Line 7, enter the overhead applicable to rural health clinic services furnished by the clinic. It is determined by subtracting line 6 (overhead applicable to services other than rural health clinic services) from line 5 (total overhead).

Line 8, enter the total cost of rural health clinic services. It is the sum of line 1 (cost of rural health clinic services) and line 7 (overhead applicable to RHC services).

PART C — DEDUCTIBLE AND COINSURANCE BILLED TO BENEFICIARIES AND NET BAD DEBT CALCULATION

Part C is used to record the deductible and coinsurance amounts billed Medicare beneficiaries from the clinic's records and to determine the net bad debt incurred by the clinic.

Line 1, enter the total deductible and coinsurance amount billed to Medicare beneficiaries.

Line 3, enter Medicare bad debts. It is determined by subtracting line 2 from line 1.

Line 4, enter any recovery of previous amounts written off as bad debts.

Line 5, enter the net bad debt amount. Line 3 less line 4.

WORKSHEET 3 — DETERMINATION OF MEDICARE REIMBURSEMENT

GENERAL

This worksheet is used by the intermediary to determine the interim all-inclusive rate of payment (for "budget" reports submitted at the beginning of a reporting period) and the total Medicare reimbursement due the clinic for the reporting period (for "actual" reports submitted after the reporting period). Part A is used to determine the interim all-inclusive rate of payment based on the "budget" report. Parts A through C are used to determine total Medicare reimbursement due for the reporting period based on the "actual" report.

PART A — DETERMINATION OF RATE FOR RURAL HEALTH CLINIC SERVICES

PART A is used by the intermediary to calculate the cost per visit for rural health clinic services and to apply the screening guideline established by HCFA on clinic health care staff productivity.

Line 1, enter the total allowable cost from W/S2, B8

Line 2, enter the greater of the minimum or actual visits by the health care staff from worksheet 2, line A4, column 5.

Line 3, enter the visits made by physicians under agreement from worksheet 2 Part A, column 5, line 5.

Line 4, enter the total of adjusted visits, sum of lines 2 and 3.

Line 5, enter the adjusted cost per visit. This is determined by dividing line 1 by line 4.

Line 6, enter the maximum rate per visit that can be received by the clinic on this line.

Line 7, enter the lesser of line 5 or line 6.

PART B — DETERMINATION OF TOTAL REIMBURSEMENT AND PAYMENT RECONCILIATION

Part B is used by the intermediary to determine the total Medicare reimbursement due the clinic for covered rural health clinic services furnished to Medicare beneficiaries during the reporting period.

Line 1, enter the Medicare rate for covered visits from line A7

Line 2, enter the number of Medicare covered visits (from intermediary records).

Line 3, enter here the Medicare cost. The Medicare cost is determined by multiplying the rate per visit on line 1 by line 2, the total number of covered Medicare beneficiary visits for rural health clinic services during the reporting period.

Line 4, enter the amount credited to the clinic's Medicare patients to satisfy their deductible liabilities on the visits in line B2 (i.e., supplementary medical insurance and blood deductible and amounts subject to the outpatient psychiatric limitation as described in section 3640.11 of the Part A Intermediary Manual) as recorded by the intermediary from clinic bills processed during the reporting period. RHC's should determine this number from the interim payment lists provided by the intermediaries.

Line 5, enter the net Medicare cost, determined by subtracting line 4 from line 3.

Line 6, enter 80 percent of line 5.

Line 7, enter the cost for pneumococcal vaccine and its administration from W/S 1.

Line 8, enter the number of pneumococcal vaccine injections from clinic record.

Line 9, enter the cost per pneumococcal vaccine injection by dividing line B7 by line B8.

Line 10, enter the number of pneumococcal vaccine injections administered to Medicare beneficiaries (from clinic records).

Line 11, enter the Medicare cost of pneumococcal vaccine and its administration (line 9 x line 10).

Line 12, enter the total Meciare cost (line B6 + B11).

Line 13, enter the total payments made to the clinic for covered services furnished to Medicare beneficiaries during the reporting period (from intermediary records).

Line 14, enter the balance due to/from the Medicare program, exclusive of bad debts, line 12 less line 13.

Line 15 enter the clinic's total reimbursable bad debts from line C8.

Line 16, enter the total amount due to/from the Medicare program (sum of lines 14 and 15). This is the amount of the payment reconciliation.

PART C — REIMBURSABLE BAD DEBTS

Part C is used by the intermediary to determine the unrecovered cost attributable to uncollected deductible and coinsurance amounts charged to beneficiaries by the clinic.

Line 1, enter the total allowable Medicare cost from line B3.

Line 2, enter the reimbursable cost of Medicare covered services from line B12.

Line 3, enter the balance of cost to be recovered from Medicare patients, line 1 less 2.

Line 4, enter the total amount billed to Medicare patients by the clinic for deductible and coinsurance amounts determined on the basis of the clinic's reasonable customary charges (from worksheet 2, Part C, line 1).

Line 5, enter the Medicare bad debts net of bad debt recoveries from clinic records (from W/S 2, Part C, line 5). This is the net total of uncollectible amounts billed Medicare beneficiaries for deductible and coinsurance determined on the basis of the clinic's reasonable customary charges.

Line 6, enter the amount of deductible and coinsurance billed to Medicare patients, net of bad debts (collectible charges for deductible and coinsurance). (Line 4 less 5).

Line 7, enter the difference between the cost to be recovered from Medicare patients and the collectible deductible and coinsurance billed as determined on the basis of charges (line 3 less 6).

Line 8, enter the total reimbursable bad debts the clinic may claim (the lesser of line 5 or 7). (This is the lesser of the cost of the bad debts or bad debts determined on the basis of the clinic's reasonable customary charges).

Form Approved
OMB. NO 0938-0107

RURAL HEALTH CLINIC WORKSHEET STATISTICAL DATA

For Intermediary Use

This report is authorized by law C42 USC. 1395g; CFR 405.2429 (C)). Failure to report can result in all payments made during the reporting period being deemed over payments.

Date Received

Intermediary Number

1. Clinic Name and Address

2. Clinic Number

3. Reporting Period From To

4. Type of Control (Check One)

A. Voluntary Non Profit
- ☐ Corporation
- ☐ Other (Specify)

B. Proprietary
- ☐ Individual ☐ Partnership
- ☐ Corporation ☐ Other (Specify)

C. Government
- ☐ Federal ☐ County
- ☐ Staff ☐ Other (Specify)
- ☐ City

5. Rural Health Clinic Owned By:

6. Other Rural Health Clinics, Providers Of Services (Hospitals, Skilled Nursing Facility, Home Health Agencies, Suppliers or Other Entities That Are Owned or Related Through Common Ownership or Control To The Individual Or Entity Listed in Item 5.

Name	Location	Clinic or Provider No.

7. Names of Physicians Furnishings Services At The Rural Health Clinic Or Under Agreements (As Described In Instructions) And Medicare Billing Numbers

Name	Billing Number

8. Supervisory Physicians

Name	Hours of Supervision For Reporting Period

FORM HCFA - 222 (3-83)

(See Reverse For Certification)

CERTIFICATION STATEMENT

Intentional Misrepresentation Or Falsification Of Any Information Contained In These Worksheets May Be Punished By Fine And/Or Imprisonment Under Federal Law

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF CLINIC

I Hereby Certify That I Have Read The Above Statement And That I Have Examined The Accompanying Worksheets Prepared By _____ For The Reporting Period Begining _____ And Ending _____
(Clinic Name And Numbers)

And That To The Best Of My Knowledge And Belief It Is A True, Correct And Complete Statement Prepared From The Books And Records Of The Clinic In Accordance With Applicable Instructions, Except As Noted

Signature (Officer Or Administrator Of Clinic)	Title	Date

Reclassification And Adjustment Of Trial Balance Of Expenses

Clinic No.

☐ Estimated ☐ Actual

Reporting Period From To

Worksheet 1 Page 1

	COST CENTER	Compensation	Other	Total (Col. 1 + 2)	Reclassifications	Reclassified Trial Balance (Col. 3 + 4)	Adjustments Increases (Decreases)	Net Expenses (Col. 5 + 6)
		1	2	3	4	5	6	7
1.	Clinic Health Care Staff Costs							
2.	Physician							
3.	Physician Assistant							
4.	Nurse Practitioner							
5.	Other Nurse							
6.	Laboratory Technician							
7.	Other (Specify)							
8.								
9.								
10.								
11.								
12.								
13.	Subtotal-Clinic Health Care Staff Costs							
14.	Physician Services Under Agreement							
15.	Physician Supervision							
16.								
17.	Other Health Care Costs							
18.	Medical Supplies							
19.	Transportation (Health Care Staff)							
20.	Depreciation-Medical Equipment							
21.	Professional Liability Insurance							
22.	Other (Specify)							
23.								
24.								
25.	Subtotal - Other Health Care Costs							
26.								
27.	Total Cost of RHC Services (Other Than Overhead							
28.	Sum Of Lines 13, 14, 15 And 25)							
29.								
30.	Clinic Overhead-Facility Cost							
31.	Rent							
32.	Insurance							
33.	Interest On Mortgage Or Loans							
34.	Facilities							
35.	Depreciation-Building							
36.	Depreciation-Equipment							
37.	Housekeeping And Maintenance							
38.	Property Tax							
39.	Other (Specify)							

FORM HCFA-222 (3-83)

Reclassification And Adjustment Of Trial Balance of Expenses

Clinic No. ☐ Estimated ☐ Actual

Reporting Period From To

Worksheet 1 Page 2

	COST CENTER	Compensation	Other	Total Col. 1 + 2)	Reclassifi-cations	Reclassified Trial Balance (Col. 3 + 4)	Adjustments Increases (Decreases)	Net Expenses (Col. 5 + 6)
		1	2	3	4	5	6	7
40.	Other (Cont'D)							
41.	Subtotal-Facility Costs (Lines 31-40)							
42.	Clinic Overhead-Administrative Cost							
43.	Office Salaries							
44.	Depreciation -Office Equipment							
45.	Office Supplies							
46.	Legal							
47.	Accounting							
48.	Insurance (Specify)							
49.	Telephone							
50.	Fringe Benefits And Payroll Taxes							
51.	Other (Specify)							
52.	Subtotal-Admistrative Cost							
53.								
54.	Total Clinic Overhead (Sum Lines 41 + 52)							
55.								
56.	Cost Other Than RHC Services							
57.	Pharmacy							
58.	Dental							
59.	Optometry							
60.	Other (Specify)							
61.								
62.								
63.								
64.	Subtotal-Cost Other Than RHC Services							
65.								
66.	Non-Reimbursable Costs (Specify)							
67.								
68.								
69.								
70.	Subtotal Non-Reimbursable Costs							
71.								
72.	Total Costs (Sum Of Lines 27, 54, 64, + 70)							

FORM HCFA-222 (3-83)

Determination of Medicare Reimbursement	Clinic No.	☐ Estimated ☐ Actual	Reporting Period From / To	Worksheet 3 Page 1

A. Determination of rate rural clinic services	AMOUNT
1. Total Allowable Costs (W/S 2, B8)	$
2. Greater of Minimum or Actual Clinic Visits By Health Care Staff (W/S 2, Line A4, Col. 5)	
3. Physicians Visits Under Agreements (W/S 2, Part A, Col. 5, Line 5)	
4. Total Adjusted Visits (Sum of Lines A2 and A3)	
5. Adjusted Cost Per Visit (Line A1 Divided By A4)	
6. Maximum Rate Per Visit	
7. Rate For Medicare Covered Visits (Lesser of A5 or A6)	

B. Determination of total reimbursement (actual reports only)	AMOUNT
1. Rate For Medicare Covered Visits (Line A7)	$
2. Medicare Covered Visits	
3. Medicare Cost (B1 x B2)	
4. Less: Beneficiary Deductible (From Intermediary Records)	
5. Net Medicare Cost (B3 Less B4)	
6. Reimbursable Cost of RHC Services, Other Than Pneumococcal Vaccine (80% x B5)	
7. Total Cost for Pneumococcal Vaccine And Its Administration (From W/S 1, Col. 6)	
8. Total Number of Pneumococcal Vaccine Injections (From Clinic Records)	
9. Cost Per Pneumococcal Vaccine Injection (Line 7 divided by B8)	
10. Total Number of Pneumococcal Vaccine Injections Administered To Medicare Beneficiaries (From Clinic Records)	
11. Medicare Cost of Pneumococcal Vaccine And Its Administration (Line B9 x B10)	
12. Total Medicare Cost (Line B6 + B11)	
13. Less Payments To Clinic During Reporting Period	
14. Balance Due To/From The Medicare Program Exclusive of Bad Debts (B12 Less B13)	
15. Total Reimbursable Bad Debts (From Line C8)	
16. Total Amount Due To/From The Medicare Program (Line B14 + B15)	$

C. Reimbursable Bad Debts	AMOUNT
1. Medicare Cost (From Line B3)	$
2. Less: Reimbursable Cost (From Line B12)	
3. Balance To Be Recovered From Medicare Patients (Line C1 Less C2)	
4. Deductible And Coinsurance Billed To Medicare Patients (From W/S 2, Part C, Line 1)	

Form HCFA-222 (3-83)

(Continued on reverse)

Visits And Overhead For Rural Health Clinic Services	Clinic No.	☐ Estimated ☐ Actual	Reporting Period From To	Worksheet 2 Page 1

Part A — Visits And Productivity

Positions	1 Number Of FTE Personnel	2 Total Visits	3 Productivity Standard	4 Minimum Visits (Col. 1 x Col. 3)	5 Greater Of Col. 2 or Col. 4
1. Physicians			4200		
2. Physician Assistants			2100		
3. Nurse Practitioners			2100		
4. Total Staff					
5. Physician Services Under Agreements					

PART B - DETERMINATION OF OVERHEAD COST APPLICABLE TO RURAL HEALTH CLINIC SERVICES

	Amount
1. Cost of RHC Services (Excluding Overhead) (W/S 1, Line 27, Col. 7)	$
2. Cost Other Than RHC Services (W/S 1, Lines 64 and 70, Col. 7)	
3. Cost of All Services (Excluding Overhead) - (Sum of Lines B1 And B2)	
4. Percentage Of Services Other Than RHC Services (Line B2 Divided By B3)	
5. Total Overhead - (W/S 1, Lines 54, Col. 7)	
6. Overhead Applicable To Services Other Than RHC Services (Multiply Line B5 By B4)	
7. Overhead Applicable To RHC Services (Line B5 Less B6)	
8. Total Cost of RHC Services (Sum Of Line B1 And B7	$

PART C - DEDUCTIBLE AND COINSURANCE BILLED TO BENEFICIARIES AND NET BAD DEBT CALCULATION

1. Deductible And Coinsurance Billed To Medicare Beneficiaries (From Clinic Records)	$
2. Deductible And Coinsurance Amounts Received From Patients (From Clinic Records)	
3. Medicare Bad Debts (Line C1 Less C2)	
4. Less: Bad Debts Recoveries (From Clinic Records)	
5. Net Bad Debts (Line C3 Less C4)	$

FORM HCFA-222 (3-83)

Determination of Medicare Reimbursement	Clinic No.	☐ Estimated ☐ Actual	Reporting Period From / To	Worksheet 3 Page 2

C. Reimbursable Bad Debts (Cont'd)	AMOUNT
5. Less: Bad Debts For Deductible And Coinsurance Net of Bad Debt Recoveries (From W/S 2, Part C, Line 5)	
6. Deductible And Coinsurance Billed To Medicare Patients Net of Bad Debts (Line C4 Less C5)	
7. Cost Unrecovered From Medicare Patients (Line C3 Less C5). (If C3 Exceeds C6, Enter Amount, If C3 is equal to or Less Than C6, Enter Zero.)	
8. Total Reimbursable Bad Debts (Lesser of C5 or C7, Enter Here and in Line B15)	

FORM HCFA-222 (3-83)

APPENDIX IX

FFHC COST REPORT - HCFA 242

FREE STANDING FEDERALLY-FUNDED HEALTH CENTER WORKSHEETS

Use of Worksheets

The federally-funded health center (FFHC) worksheets must be used by all freestanding federally-funded health centers reimbursed on the basis of charges related to cost. These forms are required for the determination of a Medicare rate of payment for services reimbursable on the basis of charges related to reasonable costs under Subpart C (42 CFR 405.312(f) of Medicare regulations.

An FFHC must complete the Statistical Data Worksheet, Worksheet 1 and Worksheet 2. These worksheets provide general information and summarize the number of encounters furnished and the costs of FFHC services. At the FFHC's option, HCFA will complete Worksheets 3 and 4 to determine the medicare rate of payment to be paid for a covered physician encounter provided a Medicare beneficiary by the FFHC. However, HCFA encourages the FFHC to complete all worksheets before submitting them.

By completing all worksheets, the FFHC can determine if reported costs exceed HCFA screening guidelines or the HCFA limit on the FFHC's rate of payment. Costs in excess of amounts established by HCFA screening guidelines (tests of reasonableness) will not be allowed in determining an FFHC rate of payment unless the FFHC provides acceptable justification as to why the additional costs are reasonable. Therefore, it is in the best interest of an FFHC to be informed of how its rate of payment is determined and, if appropriate, to submit with its completed worksheets justification for costs that exceed HCFA screening guidelines or other tests of reasonableness.

At the beginning of the FFHC's reporting period, the FFHC is required to submit two reports, one based on actual costs and encounters from the prior period and a projected report with estimated costs and encounters for the period. These reports are filed on worksheets 1 & 2 which must be completed in full by the center. Additionally, the FFHC must report actual costs and encounters, based on the FFHC's financial and statistical records, during the first six months of its reporting period. The 6-month actual report is due 60 days after the 6th month of the current reporting period while the 12-month actual and projected reports are due 90 days after the close of the reporting year.

All-Inclusive Payment Rate Methodology

The worksheets are used to determine the all-inclusive rate of payment for freestanding FFHCs (i.e., FFHCs that are not part of a hospital or other provider of services participating in the Medicare program).

To determine the all-inclusive payment rate, total allowable direct cost (after adjustments) is divided by total physician encounters, (or physician encounters determined by the HCFA productivity screens, if greater) to arrive at the allowable direct cost per encounter. An overhead rate is applied to the allowable direct cost per encounter to determine the allowable cost per physician encounter. The Medicare rate of payment is the lower of the allowable cost per encounter or the HCFA limit on the FFHC rate of payment.

An FFHC is paid 80% of the Medicare all-inclusive rate for each covered physician encounter (after the Medicare beneficiary's annual deductible has been incurred). For purposes of calculating Medicare payment rates for FFHCs under this method, an encounter is defined as a face-to-face contact for the provision of medical services between a clinic patient and a physician, physician assistant, nurse practitioner, registered nurse, or other practitioner. Contacts with more than one health professional and multiple contacts with the same health professional, that take place on the same day and at a single location, constitute a single encounter unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Medicare payment, however, may only be made for encounters between a Medicare patient and a physician for services which are covered under Part B of Medicare (Subpart B of Medicare regulations 42 CFR Part 405). Services furnished by other health care staff can be considered covered under current Medicare coverage policy only as incident-to a physician's services. For the "incident-to" services furnished in an FFHC setting to be covered under Medicare, a physician must be present in the FFHC and immediately available to provide assistance and direction. In addition there must be a physician's service rendered to which other service can be an incidental, although integral part.

In conformance with coverage rules, the all-inclusive payment rate methodology is designed to eliminate the portion of overhead and direct costs attributable to the amount of time the FFHC is open, but does not meet the physician-directed clinic requirement. Under this methodology, the portion of direct costs allowed (other than the direct cost of physician services) is based on the **percent of total encounters** furnished by a physician at the FFHC. The total reasonable direct cost of physician services is included in allowable cost.

The cost of services (other than medical and other health services) that are not covered under Medicare (i.e., pharmacy, dental, optometry, etc.) are nonreimbursable costs. The direct cost of these noncovered services are excluded in determining the allowable direct cost for the FFHC rate of payment.

Direct costs are also adjusted for costs that are disallowed under Medicare, including costs that exceed HCFA screening guidelines and other tests of reasonableness (HCFA screening guidelines are described in instructions to worksheet 3).

The FFHC worksheets delineate the rate calculation process. The following summarizes the all-inclusive payment rate methodology. All calculations must be carried to two decimal places.

A. Overhead Rate Factor (see Worksheet 4, Part A):

$$\text{Allowable overhead rate factor} = \frac{\text{Total allowable overhead}}{\text{Total direct cost,before adjustments}}$$

B. Allowable Direct Cost Factor (Percent of physician encounters)
(see worksheet 3, Part C):

$$\text{Allowable Direct Cost Factor} = \frac{\text{Total physician encounters}}{\text{Total medical encounters}}$$

C. Allowable Direct Cost for Rate Determination (see worksheet 4, Part B):

Total Allowable Direct Cost = 100% of direct cost of physician services plus (total reimbursable direct cost minus direct cost of physician services) x allowable direct cost factor)

D. Overhead Cost Per Encounter (see worksheet 4, Part C):

$$\text{Overhead Cost Per Encounter} = \frac{\text{Total allowable direct cost}}{\text{Total physician encounters}} \times \text{Allowable overhead rate factor}$$

E. All-inclusive Rate of Payment (see worksheet 4, Part C):

All-inclusive Rate of Payments = Allowable direct cost per physician encounter + overhead cost per encounter

F. Medicare Rate of Payment (see worksheet 4, Part C):

Lesser of all-inclusive rate of payment or HCFA limit on FFHC rate of payment.

The FFHC is reimbursed 80 percent of the Medicare rate of payment (after the Medicare beneficiary's annual deductible has been incurred) for each physician encounter for services covered under Part B of Medicare.

STATISTICAL DATA

Item 1: **CLINIC NAME AND ADDRESS.** Enter here the full name and address of the FFHC.

Item 2: **CLINIC NUMBER.** Enter the FFHC identification number that was provided by HCFA when clinic entered program.

Item 3: **REPORTING PERIOD.** Enter the inclusive dates covered by this report. With the exception of the 6-month actual report, a reporting period is a period of 12 consecutive months specified by the intermediary as the period for which the FFHC must report its costs and utilization. The first and last reporting periods may be less than 12 months.

Item 4: **SOURCE OF FEDERAL FUNDS.** Indicate by a check mark the types of federal funds received and enter the grant award number and the date it was awarded.

Item 5: **FEDERALLY FUNDED HEALTH CLINIC OWNED BY.** Enter the name of the organization(s) or individual(s) who are the legal owner(s) of the FFHC, or if FFHC is controlled by a non-profit organization, so state.

Item 6: **RELATED ORGANIZATIONS.** List all clinics, providers of services, (hospitals, skilled nursing facilities, home health agencies) suppliers or other entities that are owned, or related through common ownership or control, to the individual or entity listed in item 5.

Item 7: **PHYSICIANS PROVIDING SERVICES TO FFHC.** List all physicians furnishing services at the FFHC or under agreements and their Medicare billing numbers.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF CLINIC. This certification must be prepared and signed after the cost report has been completed in its entirety The individual signing must be an officer or other authorized responsible person.

Preparer of Report: Enter the name and telephone number of the person who prepared the report in case further information or clarification of the report is required.

WORKSHEETS

WORKSHEET I - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

General Instructions

This worksheet provides for recording the trial balance of expense accounts from the FFHC's accounting books and records. (For six months and end of year cost reports, the FFHC should use its actual trial balance. For budgeted reports, an estimated trial balance should be used.) The worksheet also provides for any necessary reclassification and adjustments to these accounts.

Not all of the listed cost centers will apply to each FFHC. For example, a FFHC might not employ radiology technicians and would not, in that case, complete line 12. The worksheet also provides blank lines for clinic costs and cost centers in addition to those listed in the form. If the worksheet does not provide sufficient space, enter aggregate amounts on Worksheet 1 under "other," where appropriate, and furnish a supporting schedule to list items included in the aggregate amounts.

Columns 1 through 3 - TRIAL BALANCES OF DIRECT EXPENSES

For actual cost reports, the expenses listed in these columns must be in accordance with the FFHC's accounting books and records.

Enter on the appropriate lines in columns 1 through 3 the total expenses incurred during the reporting period. The expenses must be detailed between compensation (column 1), and other than compensation and related costs (column 2). The sum of columns 1 and 2 must equal column 3. Any needed reclassifications and adjustments must be recorded in columns 4 and 6, as appropriate.

Column 4 - RECLASSIFICATION

This column is used to reclassify expenses among the cost centers for proper grouping of expenses. Reclassifications are used in instances in which the expenses applicable to more than one of the cost centers listed on the worksheet are maintained in the FFHC's accounting books and records in one cost center. For example, if a physician performs some administrative duties, the appropriate portion of his compensation, and applicable payroll taxes and fringe benefits, would need to be reclassified from "FFHC Health Care Staff Cost" to "FFHC Over head - Administrative Cost Incurred." Reduction to expenses should be shown in brackets [ ]. The net total of the entries in column 4 must equal zero.

Column 5 - RECLASSIFIED TRIAL BALANCE

This column is the sum of columns 3 and 4. The net balance for each line is entered in column 5. The total of column 5 on line 66 must equal the total of column 3 on line 66.

Column 6 - ADJUSTMENTS

This column is used to indicate the amount of any adjustments to the FFHC's reclassified expenses. Adjustments may be required to increase or decrease expenses in accordance with the Medicare rules on allowable costs. Examples of situations in which adjustments to expenses would be required are:

1. the FFHC has transactions with a related organization;
2. the FFHC receives restricted grants and gifts;
3. the FFHC depreciates assets on other than an acceptable basis, recognized by Medicare;
4. the FFHC receives an allocation of cost from a home office;
5. the clinic has a practitioner assigned by the National Health Service Corps.

Decreases to expenses are shown in brackets [ ]

Column 7 - NET EXPENSES

This column is the sum of columns 5 and 6: The net balance of each line item is entered in column 7

LINE DESCRIPTION

Lines 1 - 18 - FFHC HEALTH CARE STAFF COSTS

On lines 2 through 15, the costs of the FFHC's health care staff are entered by type of staff. Total compensation received by members of the National Health Service Corps (NHSC) is an allowable cost. Centers should show actual payments to NHSC staff in column 1--compensation. The difference between the staff's total compensation and what the FFHC actually paid should be shown as an increase in column 6. Line 2, column 7, is transferred to W/S 4, line B-6. Line 15, column 5 is transferred to W/S 3 line D-9.

Line 20 - PHYSICIAN SERVICES UNDER AGREEMENT

On this line enter the cost to the FFHC of medical services furnished under agreement by a physician who is not an owner or an employee of the FFHC. These physician services may be performed on-site at the FFHC or at a location other than the FFHC (such as, the physician's office, an institution, the patient's home or other location.) Line 20, column 7, is transferred to W/S 4, line B-7.

Lines 23 - 31 - OTHER HEALTH CARE COSTS

Enter on these lines the costs directly related to the delivery of medical and other health care services. Include only those items **directly related to patient care** which have not been included in any other cost center. The following services should be excluded the cost of physicians and other health care staff, overhead, cost attributable to non-reimbursable cost centers such as pharmacy, dental, etc.

Line 33 - TOTAL COST OF MEDICAL AND OTHER HEALTH CARE SERVICES (EXCLUDING OVERHEAD)

Line 33 is the total cost of FFHC services (excluding overhead and nonreimbursable cost centers).

Lines 35 - 38 - NONREIMBURSABLE COST CENTERS (EXCLUDING OVERHEAD)

Enter on these lines the cost of services that are not reimbursable under Medicare. The cost of these services and encounters attributable to these noncovered services are excluded in determining the allowable direct cost for the FFHC rate of payment.

Line 40 - TOTAL DIRECT COST

Line 40 is the total of medical and other health care services costs and nonreimbursable costs. It is the sum of lines 33 and 39. Transfer amount in column 7 to line A2 worksheet 4.

Lines 42 - 52 - FFHC OVERHEAD - FACILITY COST

Enter on these lines the overhead cost related to the FFHC's facility. This includes the cost to own, lease or rent, and to maintain and improve FFHC buildings and building equipment.

Lines 53 - 63 - OVERHEAD - ADMINISTRATIVE COST

Enter on these lines the expenses related to the administration and management of the FFHC.

Line 64 - TOTAL OVERHEAD

Line 64 is the sum of lines 52 and 63. Transfer total amount in column 7 to line A1 of worksheet 4.

Line 66 - TOTAL COST

Line 66 is the total cost of the clinic and is the sum of lines 40 and 64.

WORKSHEET 2 - FFHC MEDICAL SERVICES STATISTICS

This worksheet is used to record the fulltime equivalent (FTE) medical services personnel and to summarize the number of FFHC medical encounters furnished by the health care staff. Exclude statistics on FTEs and encounters for non-reimbursable cost centers (such as dental and optometry) and overhead cost centers (such as administrative staff).

Line 1-18 of this worksheet lists statistics for physicians and other health care staff who are owners or employees of the FFHC. Statistics for donated services should also be included in these lines in each category of staff applicable. Statistics on purchased services of health care staff other than physicians should be included on the appropriate line with the employees staff.

Line 21 - Physician Medical Services Under Agreement

Enter on this line the statistics on physicians under agreement with the FFHC. "Physicians' services under agreement" with the center means (1) all medical services performed at the FFHC site by a physician who is not the owner or an employee of the center, and (2) medical services performed at a location other than the FFHC site by such a physician for which the physician is compensated by the center. While all physician services at the FFHC must be included under cost reimbursement, physician services furnished in other locations by physicians who are not on the full-time staff of the FFHC are reimbursable to the center only if the FFHC's agreement with the physician provides for compensation for such services.

Column 1 - FULL-TIME PERSONNEL EQUIVALENTS (FTEs)

This column is used to record the number of FTE personnel in each position. Full-time equivalency is determined by dividing the total hours worked by all personnel in each position by the number of hours the clinic considers to be full-time for that position. The number of hours used by a clinic as full-time equivalency must be at least 1600 hours per year. Fractional amounts are shown to the first decimal place.

Column 2 - HEALTH SERVICES HOURS ON-SITE

This column is used to record the number of hours spent by all personnel in each of the applicable staff positions in the FFHC. The FFHC should record the number of hours in which each staff member was present at the FFHC facility and available to furnish medical services. The time spent in other activities, such as clinic management, should be excluded.

ENCOUNTERS

Column 3 - ON SITE

This column is used to record all encounters of health care staff furnished at the FFHC site. An encounter is a face-to-face contact for the provision of medical service between a clinic patient and a physician, physician assistant, nurse practitioner, registered nurse or other practitioner. Contacts with more than one health professional and multiple contact with the same health professional that take place on the same day at a single location constitute a single encounter unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

Column 4 - OFFSITE

Enter in this column all off-site encounters made by health care staff at locations other than the FFHC facilities.

Column 5 - TOTAL

Enter in this column the sum of encounters recorded in columns 3 and 4.

WORKSHEET 3 - SCREENING GUIDELINES AND ALLOWABLE DIRECT COST FACTOR

Part A - **APPLICATION OF SCREENING GUIDELINES FOR PHYSICIAN PRODUCTIVITY**

This part is used to summarize the FFHC staff physician encounters to be used in the rate determination in accordance with productivity standards established by the Health Care Financing Administration (HCFA).

Line 1

Enter on this line total staff physician on-site encounters from W/S 2, line 1, column 3.

Line 2

Enter on this line the productivity standards in accordance with the following guideline.

HCFA SCREENING GUIDELINE FOR PHYSICIAN PRODUCTIVITY

Year of FFHC Operation	Percentage of Expected Productivity of Three Encounters per Hour	Encounters for Screening Guideline
1st year	40%	1.2
2nd year	50%	1.5
3rd year	60%	1.8
4th year	70%	2.1
5th year	80%	2.4
After 5th year	80%	2.4

Line 3

Enter on this line the hours that staff physicians were on-site from W/S 2, line 1, column 2.

Line 4

Determine minimum staff physician on-site encounters by multiplying line A 3 by A 2.

Line 5

Enter on this line the number of physician staff encounters from line A 1 or A 4, whichever is greater.

Part B - **PHYSICIAN ENCOUNTERS FOR DETERMINATION OF FFHC RATE OR PAYMENT**

This part is used to determine total physician encounters for calculating the FFHC rate of payment.

Line 1

Enter the on-site physician encounters from line A 5.

Line 2

Enter all off-site physician encounters from W/S 2, line 1, column 4.

Line 3

Enter all encounters performed by physicians under agreement from W/S 2, line 21, column 5.

Line 4

Enter the sum of lines B 1, B 2, and B 3.

Part C - **DETERMINATION OF ALLOWABLE DIRECT COST FACTOR**

This part is used to calculate direct cost factor for FFHCs.

Line 1

Enter on this line the total number medical encounters for the reporting period from W/S 2, line 25, column 5.

Line 2

Enter on this line the total physician encounters W/S 2, lines 1 and 21, column 5.

Line 3

Enter on this line the percentage rate for encounters furnished by physicians. (Divide line C 2 by line C1.)

Part D - **APPLICATION OF HCFA SCREENING GUIDELINE FOR NON-PHYSICIAN HEALTH CARE STAFF**

This part is used to determine the allowable direct cost for non-physician health care staff.

Line 1

Enter on this line the staff physician FTE's from W/S 2, line 1, column 1.

Line 3

Enter on this line the greater of lines D 1 or D 2.

Line 4

Entered on this line is the number 4, the current HCFA screening guidline of four support staff to each FTE physician. This screen applies only to direct medical personnel (i.e., nurses, technicians, physician assistants, nurse practitioners, etc.). Included as medical personnel for purposes of screening support staff costs are staff whose duties are specific to a department's direct medical function rather than general administrative duties. It does not apply, however, to staff included in overhead costs or to staff included in the nonreimbursable cost centers (such as pharmacy and dental).

Line 5

Enter on this line the maximum non-physician staff allowed. Calculate this amount by multiplying line D 3 by line D 4.

Line 6

Enter on this line the actual non-physician FTE from W/S 2, line 15, column 1.

Line 7

Enter on this line the lesser of lines D 5 or D 6.

Line 8

Enter the percentage of staff allowed by dividing line D 7 by line D 6.

Line 9

Enter the non-physician health care staff cost from W/S 1, line 15, column 7

Line 10

Enter the allowable non-physician staff cost. This amount is determined by multiplying line D 8 by line D 9

WORKSHEET 4 - FFHC RATE OF PAYMENT CALCULATION

This worksheet is used to determine the rate of payment for both physician-directed FFHCs and nonphysician-directed FFHCs

Part A - **ALLOWABLE OVERHEAD RATE FACTOR**

This part is used to calculate the allowable overhead rate factor

Line 1

Enter on this line the total overhead amount from W/S 1, line 64, column 7.

Line 2

Enter on this line total direct cost from W/S 1, line 40, column 7

Line 3

Enter on this line the sum of lines A 1 and A 2.

Line 5

Enter on this line the overhead guideline amount. This amount is calculated by multiplying line A 3 by line A 4.

Line 6

Enter on this line the lessor of line A 1 or line A 5.

Line 7

Enter on this line the percentage rate for allowable overhead costs. This is calculated by dividing line A 6 by line A 2.

Part B - **ALLOWABLE DIRECT COST FOR RATE DETERMINATION**

This part is used to calculate the total allowable direct cost for determining the FFHC rate of payment.

Line 1

Enter the non-physician staff cost from W/S 3, line D 10

Line 2

Enter other health care cost from W/S 1, line 31, column 7

Line 3

Enter the sum of lines B 1 and B 2

Line 4

Enter the direct cost factor from W/S 3, line C 3

Line 5

Enter the allowable direct cost by multiplying line B 3 by B 4

Line 6

Enter the staff physician cost from W/S 1, line 2, column 7

Line 7

Enter the cost of physician services under agreement from W/S 1, line 20, column 7

Line 8

Enter the total allowable direct cost by adding lines B 5, B 6 and B 7

Part C - **RATE OF PAYMENT**

This part is used to determine the FFHC rate of payment.

Line 1

Enter on this line the total allowable direct cost from line B 5.

Line 2

Enter here the total number of physician encounters from W/S 3, line B 4

Line 3

Enter here the allowable direct cost per physician encounter. Divide line C 1 by C 2.

Line 4

Enter here the allowable FFHC overhead rate factor from line A 7.

Line 5

Enter here the overhead cost per encounter (line C 3 multiplied by C 4).

Line 6

Enter the all-inclusive payment rate by adding lines C 3 and C 5.

Line 7

Enter on this line the HCFA limit on the FFHC rate of payment for the State in which the FFHC facility is located. This limit is calculated by HCFA annually for each State from maximum area prevailing charges for services similar to those routinely rendered in most centers. HCFA will advise the FFHC of the payment limit as it becomes available.

Line 8

Enter on this line the rate of payment for each covered physician encounter provided a Medicare beneficiary. This amount is the lessor of line C 6 or line C 7. (The FFHC is reimbursed 80% of this rate of payment after the Medicare beneficiary's annual deductible has been incurred.)

FREESTANDING FEDERALLY-FUNDED HEALTH CENTER WORKSHEETS
STATISTICAL DATA

1. Clinic Name and Address	2. Clinic Number	
	3. Reporting Period From	To

4. Source of Federal Funds	GRANT AWARD NUMBER	DATE
A. Community Health Center (Section 330 (d), Public Health Service Act)		
B. Migrant Health Center (Section 329 (d), PHS Act)		
C. Community Mental Health Center (Section 201 at seq. Community Mental Health Centers Act of 1975)		
D. Appalachian Regional Commission		
E. Other (Specify)		

5. Federally-funded health clinic owned by:

6. Other clinics, providers of services (hospital, skilled nursing facility, home health agency) suppliers or other entities that are owned, or related through common ownership or control, to the individual or entity listed in item 5.

NAME	LOCATION	CLINIC OR PROVIDER NO.

7. Name of physicians (employed by the FFHC and physicians furnishing FFHC services under agreement) and Medicare billing numbers.

NAME	BILLING NUMBER

FORM HCFA-242 (10-83)

FORM APPROVED
OMB NO. 0938-0235

CERTIFICATION STATEMENT

Intentionel misrepresentetion or felsificetion of eny informetion conteined in these worksheets may be punisheble by fine end/or imprisonment under Federel lew.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF CLINIC

I hereby certify thet I heve read the ebove Statement end thet I heve exemined the eccompenying worksheets for the indiceted reporting period, end that to the best of my knowledge end belief it is e true, correct end complete Statement prepered from the books end records of the clinic in accordance with epplicable instructions, except as noted.

1. Signeture of Officer or Administretor of Clinic	2. Title	3. Dete
4. Clinic Name end Number	5. Period: Beginning Ending	
6. Name of Person Preparing This Report	7. Telephone Number ( )	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0235

FEDERALLY-FUNDED HEALTH CENTER (FFHC) RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

CLINIC NO.

☐ ESTIMATED ☐ ACTUAL

REPORTING PERIOD FROM TO

WORKSHEET 1
PAGE 1

COST CENTER (OMIT CENTS)	COMPENSATION	OTHER	TOTAL (COL. 1 & 2)	RECLASSI-FICATIONS	RECLASSIFIED TRIAL BALANCE (COL. 3 & 4)	ADJUSTMENTS INCREASES (DECREASES)	NET EXPENSES (COL. 5 & 6)
	1	2	3	4	5	6	7
1. FFHC HEALTH CARE STAFF COSTS:							
2. Physician							
3.							
4. NON-PHYSICIAN HEALTH CARE STAFF							
5. Physician Assistant							
6. Nurse Practitioner							
7. Specialized Nurse Practitioner							
8. Nurse Midwife							
9. Visiting Nurse							
10. Other Nurse							
11. Laboratory Technician							
12. Radiology Technician							
13. Other (Specify)							
14.							
15. SUBTOTAL-NONPHYSICIAN HEALTH CARE STAFF							
16.							
17. SUBTOTAL - Health Care Staff Costs							
18. (sum of lines 2 and 15)							
19.							
20. PHYSICIAN SERVICES UNDER AGREEMENT							
21.							
22.							
23. OTHER HEALTH CARE COSTS:							
24. Medical Supplies							
25. Transportation (Health Care Staff)							
26. Depreciation - Medical Equipment							
27. Professional Liability Insurance							
28. Other (Specify)							
29.							
30.							
31. SUBTOTAL-Other Health Care Costs							
32.							
33. TOTAL COST OF MEDICAL AND OTHER HEALTH SERVICES EXCLUDING OVERHEAD (SUM OF LINES 17, 20 AND 31)							

FORM HCFA 242 (10-83)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0235

FEDERALLY-FUNDED CENTER (FFHC)
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

CLINIC NO.

☐ ESTIMATED ☐ ACTUAL

REPORTING PERIOD FROM TO

WORKSHEET 1
PAGE 2

COST CENTER (OMIT CENTS)	COMPENSATION	OTHER	TOTAL (COL. 1 & 2)	RECLASSI-FICATIONS	RECLASSIFIED TRIAL BALANCE (COL. 3 & 4)	ADJUSTMENTS INCREASES (DECREASES)	NET EXPENSES (COL. 5 & 6)
	1	2	3	4	5	6	7
35. NON-REIMBURSABLE COST CENTERS (SPECIFY):							
36.							
37.							
38.							
39. SUBTOTAL — Non-reimbursable Cost Centers							
40. TOTAL DIRECT COST (Sum of lines 33 and 39)							
41.							
42. OVERHEAD - FACILITY COST							
43. Rent							
44. Insurance							
45. Interest on Mortgage or Loans							
46. Utilities							
47. Depreciation - Building							
48. Depreciation - Equipment							
49. Housekeeping and Maintenance							
50. Property Taxes							
51. Other (Specify)							
52. SUBTOTAL - Facility Cost							
53. OVERHEAD - ADMINISTRATIVE COST							
54. Office Salaries							
55. Depreciation - Office Equipment							
56. Office Supplies							
57. Medical Records							
58. Legal and Accounting							
59. Insurance (Specify)							
60. Telephone							
61. Fringe Benefits and Payroll Taxes							
62. Other (Specify)							
63. SUBTOTAL - ADMINISTRATIVE COST							
64. TOTAL OVERHEAD (SUM OF LINES 52 AND 63)							
65.							
66. TOTAL COST (SUM OF LINES 40 AND 64)							

FORM HCFA-242 (10-83)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCIAL ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0235

FFHC MEDICAL SERVICES STATISTICS	CLINIC NO. ☐ ESTIMATED ☐ ACTUAL	REPORTING PERIOD FROM	TO	WORKSHEET 2

MEDICAL SERVICES PERSONNEL EQUIVALENTS, HOURS ON-SITE, AND ENCOUNTERS

MEDICAL SERVICES PERSONNEL	FULL TIME PERSONNEL EQUIVALENTS (FTEs) (2)	HEALTH SERVICES HOURS ON-SITE	ENCOUNTERS		
			ON-SITE	OFF-SITE	TOTAL
	1	2	3	4	5
1. Physicians (Staff)					
2.					
3. Other Health Care Staff (1)					
4. Physician Assistants					
5. Nurse Practitioners					
6. Specialized Nurse Practitioners					
7. Nurse Midwives					
8. Other Nurses					
9. Laboratory Technicians					
10. Radiology Technicians					
11. Others (Specify)					
12.					
13.					
14.					
15. SUBTOTAL - Other Health Care Staff					
16.					
17.					
18. TOTAL - Staff (Sum of lines 1 and 15)					
19.					
20.					
21. Physician Medical Services Under Agreement					
22.					
23.					
24.					
25. TOTAL (Sum of lines 18 and 21)					

(1) Medical services support staff excluding administrative and other staff included in FFHC Overhead Costs or non-reimbursable cost centers.

(2) Refer to instructions for explanation of full-time equivalents (FTEs)

FORM HCFA-242 (10-83)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0235

SCREENING GUIDELINES AND ALLOWABLE DIRECT COST FACTOR	CLINIC NUMBER ☐ESTIMATED ☐ACTUAL	REPORTING PERIOD FROM	TO	WORKSHEET 3

PART A — APPLICATION OF SCREENING GUIDELINE FOR PHYSICIAN PRODUCTIVITY

DETERMINATION OF FFHC STAFF PHYSICIAN ON-SITE ENCOUNTERS FOR CALCULATION OF FFHC RATE OF PAYMENT	
1. Total staff physician on-site encounters (W/S 2, line 1, Col. 3)	
2. HCFA screening guideline for staff physicien on-site encounters	
3. Staff physician on-site health services hours for the reporting period (W/S 2, line 1, Col. 2)	
4. Minimum staff physicien on-site encounters for determination of FFHC rate of payment (line A3 multiplied by line A2)	
5. Staff physicien on-site encounters to be used for determination of FFHC rate of payment (lines A1 or A4, whichever greeter)	

PART B — PHYSICIAN ENCOUNTERS FOR DETERMINATION OF FFHC RATE OF PAYMENT

PHYSICIAN ENCOUNTERS	
1. Staff physician on-site encounters (line A5)	
2. Staff physician off-site encounters (W/S 2, line 1, Col. 4)	
3. Physician medical services under arrangement (W/S 2, line 21, Col. 5)	
4. Totel physician encounters for determination of FFHC rate of payment (sum of lines B1, B2, and B3)	

PART C — DETERMINATION OF ALLOWABLE DIRECT COST FACTOR

DETERMINATION OF ALLOWABLE DIRECT COST FACTOR (PERCENT OF TOTAL ENCOUNTERS FURNISHED BY A PHYSICIAN)	
1. Total encounters at FFHC (W/S 2, line 25, Col. 5)	
2. Total physician encounters at FFHC (W/S 2, lines 1 and 21, Col. 5)	
3. Allowable direct cost factor (percent of encounters furnished by a physician) (line C2 divided by line C1)	

PART D — APPLICATION OF HCFA SCREENING GUIDELINE FOR NON-PHYSICIAN HEALTH CARE STAFF

1. Staff physician FTEs (W/S 2, line 1, Col. 1)	
2. Minimum FTE physicians for calculation of guideline	1.0
3. FTE physicians for calculation of guideline (GREATER of lines D1 or D2)	4.0
4. HCFA guideline	
5. Meximum non-physician staff (line D3 multiplied by line D4)	
6. Actual non-physician FTE (W/S 2, line 15, Col. 1)	
7. Allowable non-physician staff (lesser of lines D5 or D6)	
8. Percentage of staff allowed (line D7 divided by line D6)	
9. Non-physician health care staff cost (W/S 1, line 15, Col. 7)	
10. Non-physician staff cost after epplication of guideline (line D8 multiplied by line D9)	

FORM HCFA-242 (10-83)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0236

FFHC RATE OF PAYMENT	CLINIC NUMBER ☐ESTIMATED ☐ACTUAL	REPORTING PERIOD FROM	TO	WORKSHEET 4

PART A – ALLOWABLE OVERHEAD RATE

1. Total overhead cost (W/S 1, line 64, Col. 7)	
2. Total direct cost (W/S 1, line 40, Col. 7)	
3. Sum of lines A1 and A2	
4. HCFA screening guideline for FFHC overhead cost	30%
5. FFHC overhead guideline amount (line A3 multiplied by line A4)	
6. Allowable overhead cost (lesser of A1 or A5)	
7. Allowable overhead rate (line A6 divided by line A2)	

PART B – DIRECT COST FOR RATE DETERMINATION

1. Non-physician staff cost (W/S 3, line D10)	
2. Other health care cost (W/S 1, line 31, Col. 7)	
3. Sum of lines B1 and B2	
4. Direct cost factor (W/S 3, line C3)	
5. Allowable direct cost, excluding physician cost (line B3 multiplied by B4)	
6. Staff physician cost (W/S 1, line 2, Col. 7)	
7. Cost of physician services under agreements (W/S 1, line 20, Col. 7)	
8. Total allowable direct cost (sum of lines B5, B6, and B7)	

PART C – RATE OF PAYMENT

1. Total allowable direct cost for rate determination (line B5)	
2. Total physician encounters for rate determination (W/S 3, line B4)	
3. Allowable direct cost per physician encounter (line C1 divided by C2)	
4. Allowable FFHC overhead rate factor (line A7)	
5. Overhead cost per encounter (line C3 multiplied by C4)	
6. All-inclusive rate of payment (sum of line C3 and C5)	
7. HCFA limit on FFHC rate	
8. Medicare payment rate (lesser of C6 or C7)	

FORM HCFA-242 (10-83)

VI. BIBLIOGRAPHY

Ambulatory Care Services for the Aged

Austin LB and Weyrauch EP. "The Role of the Registered Nurse in a Practical New Approach to Delivery of Gerontological Care." American Nurses Association Publications G-147 (1980): 14-21.

Branch L ... [et al]. "Toward Understanding Elders' Health Service Utilization." Journal of Community Health 7 #2 (Winter 1981): 80-92.

Brandt KD ... [et al]. "How Financial Barriers Can Frustrate Good Arthritis Care." Geriatrics 43 #5 (May 1988): 83-8.

Cromley EK and Shannon GW. "Locating Ambulatory Medical Care Facilities for the Elderly." Health Services Research 21 #4 (October 1986): 499-514.

Epstein AM ... [et al]. "Consultative Geriatric Assessment for Ambulatory Patients: A Randomized Trial in a Health Maintenance Organization." JAMA (26 January 1990):

Evanshwick C ... [et al]. "Factors Explaining the Use of Health Care Services by the Elderly." Health Services Research 19 #3 (August 1984): 357-82.

Fisher CR. "Trends in Medicare Enrolle Use of Physician and Supplier Services, 1983-86." Health Care Financing Review 10 #1 (Fall 1988): 1-15.

Fretwell MD, Cutler C and AM Epstein. "Outpatient Geriatric Assessment in a Health Maintenance Organization: Its Structure, Practice and Clinical Implications." Clinics in Geriatric Medicine 3 #1 (February 1987): 185-91.

Gildea J. "Toil and Trouble Over Outpatient Prospective Payment." Health Cost Management 5 #1 (January-February 1988): 1-10.

Helbing C and Latta VB. "Use and Cost of Hospital Outpatient Services Under Medicare, 1985." Health Care Financing Review 9 #4 (Summer 1988): 113-25.

Hickey T and Rakowski W. "Consistency in Patients Health and Treatment Expectations at a Geriatric Clinic." Journal of the American Geriatric Society 29 #6 (June 1981): 278-84.

Infante-Rivand C ... [et al]. "A Telephone Support Service to Reduce Medical Care Use Among the Elderly." Journal of the American Geriatric Society 36 #4 (April 1988): 306-11.

Inglehart JK. "The New Law on Medicare's Payments to Physicians." The New England Journal of Medicine 322 #7 (April 26, 1990).

Ingman SR and Lawson IR. "Utilization of Specialized Ambulatory Care by the Elderly: A Study of a Clinic." Medical Care 20 #3 (March 1982): 331-8.

Kane RL. "Contrasting the Models: Reflections on the Pattern of Geriatric Evaluation Care." Clinics in Geriatric Medicine 3 #1 (February 1987): 225-30.

Kerson TJ. "Nonresidential Service to Elderly People." Health and Social Work 14 #3 (August 1989): 220-1.

Illinois Department on Aging and U.S. Public Health Service. "Coordinated Planning for the Rural Elderly: A Guidebook for Area Agencies on Aging and Community Health Centers."

La Jolla Management Corporation. "Final Report - Assessment of the Current Utilization of C/MHCs by the Elderly and an Assessment of the Capability of C/MHCs to Develop Comprehensive Community-Based Primary Care Health Services for the Elderly." HRSA Contract # 240-86-0093 (1987).

Leesman KS. "Addressing the Needs of the 'Frail Elderly': A Model and Guideline for Strategic Planning." Hospital Forum 23 #5 (July/August 1980): 23-6.

Maclennan WJ and Hall MR. "Geriatric Clinics in General Practitioner Surgeries." Practitioner 224 (1345) (July 1980): 687-9.

Master RJ ... [et al]. "A Continuum of Care for the Inner City: Assessment of its Benefits for Boston's Elderly and High-Risk Populations." New England Journal of Medicine 302 #26 (June 1980): 1434-40.

Moore JT ... [et al]. "Evolution of a Geriatric Evaluation Clinic." Journal of the American Geriatric Society 32 #12 (December 1984): 900-5.

"More outpatient facilities participate in Medicare." Health Care Strategic Strategic Management 6 #5 (May 1988): 22,24.

National Association of State Units on Aging, State Units on Aging: Understanding Their Roles and Responsibilities, 2nd edition, (1987).

Neal TR, Mercer JS and RL Valentine. "Medicare Reimbursement Issues." Topics in Health Care Financing 13 #1 (Fall 1986): 41-56.

Parsons MT and Nilsson PJ. "Nurse-Managed Gerontological Centers." Nebraska Nurse 18 #4 (November 1985): 12-5.

Robey PE and Snyder LS. "Medicare: The Frustrations of Ambulatory Care Coverage." Physician Executive 12 #4 (July-August 1986): 16-17.

Rahtz DR, Joyce DR and GW Paul. "Health Care Concerns of the Older Consumer: Implications for Ambulatory Care." Journal of Ambulatory Care Management 12 #3 (August 1989): 52-60.

Rakowski, W.; "Temporal Context and the Perceptions of Geriatric Patients"; Social Science and Medicine; 1982.

Rivnyak MH ... [et al]. "Ambulatory Care Use Among the Noninstitutionalized Elderly: A Causal Model." Research on Aging 11 #3 (September 1989): 292- 311.

Russell LB and Manning CL. "The Effect of Prospective Payment on Medicare Expenditures." New England Journal of Medicine 320 #7 (16 February 1989): 439-44.

Schlag WA and Piktialis DS. "Health Maintenance Organizations and the Elderly: The Potential for Vertical Integration of Geriatric Care." QRB 13 #4 (April 1987): 140-7.

Select Committee on Aging (U.S. House) Subcommittee on Health and Long-Term Care; New Perspectives in Health Care for Older AMericans: Recommendations and Policy Directions of the Subcommittee on Health and Long-Term Care; Washington, D.C., January, 1976.

Taler GA and Waymack MH. "Ethics and the Elderly." Primary Care 16 #2 (June 1989): 529-41.

Updaw RJ. "Free-standing Emergency Centers and Ambulatory Surgery Centers: Evaluating Feasibility and Assessing Impact on Hospital Operations." Topics in Health Care Financing 13 #3 (Spring 1987): 60-7.

Vickery DM ... [et al]. "The Effect of Self-Care Interventions on the Use of Medical Services Within a Medicare Population." Medical Care 26 #6 (June 1988): 580-8.

Waldo DR and Lazenby, HC. "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United State: 1977 - 1984." Health Care Financing Review 6 #1 (Fall 1984): 1 - 29.

Williams ME. "Outpatient Geriatric Evaluation." Clinics in Geriatric Medicine 3 #1 (February 1987): 175-83.

Williams ME and Williams TF. "Evaluation of Older Persons in Ambulatory Setting." Journal of the American Geriatrics Society 34 #1 (January 1986): 37-43.

Wolf-Klein GP and Silverstone FA. "A Hot-Line Emergency Service for the Ambulatory Frail Elderly." Gerontologist 27 #4 (August 1987): 437-9.

Wong S, Wong J and M Arklie. "A Mobile Health Assessment Program for the Elderly." Canadian Nurse 81 #3 (March 1981): 27-31.

Yeo G ... [et al]. "Effects of a Geriatric Clinic on Functional Health and Well-Being of Elders." Journal of Gerontology 42 #3 (May 1987): 252-8.

CASE STUDIES

NORTHWEST HEALTH SERVICES

MOUND CITY, MISSOURI

I. GENERAL PROJECT DESCRIPTION

Background:

Northwest Health Services (NHS), located in the northwest corner of Missouri, was founded in 1984 by a group of local citizens concerned about the future of health services in rural Holt County. The new organization incorporated three previously separate private medical practices into a single not-for-profit entity. Two of these three general practitioners were close to retirement, and no other medical services existed within the county, or even within a thirty mile radius of Mound City, the largest town. (The organization also negotiated with a fourth provider, but he passed away before an agreement was reached.) Soon after its founding, NHS further expanded operations to include Atchison County to the north, an area which shared the rural nature of Holt County and its dependence upon aging physicians. NHS now manages two hospital-owned medical practices in Atchison County. The combined populations of the two counties, actually shrinking slightly each year, is 15,487.

Seventy percent (70%) of Holt County residents are classified as non-farm rural, with the balance (30%) classified as rural farm. All residents are labelled rural because no town in the county has a population exceeding 2,500. Distance to services is not the only barrier to health care, however. The area is extremely poor with one-half of the non-Medicare and non-Medicaid population below the minimum U.S. poverty guidelines in 1987. The crisis in farm economics, leading to the loss of many traditional row crop and cattle family farms throughout the midwest, was exacerbated by a severe drought in 1988.

The area also has an extremely large population of elderly, many of whom have mobility problems. Missouri ranks fifth in the nation in terms of the proportion of total population aged sixty-five and over. And, while the total state population is expected to increase by approximately eight percent (8%) from 1980 to 2000, the frail elderly segment of the population, those seventy-five years of age and older, is expected to grow by approximately thirty-four percent (34%), according to the Missouri Center for Health Statistics. Thirty-six percent (36%) of Holt County's and thirty-five percent (35%) of Atchison County's population is aged fifty-five (55) or older.

Services:

NHS currently operates three clinics in Holt County, (Mound City, Oregon and Maitland) in addition to the two managed facilities (Rock Port and Tarkio) in Atchison County. The clinics are generally open during weekday hours, and the largest, Mound City, is open on Saturday mornings as well. Four physicians, two of whom are semi-retired and part-time, and one family nurse practitioner form the provider staff for the owned clinics and ostensibly share off-hours (weekend) call. NHS is currently actively recruiting for full-time physicians/providers for both the Oregon and Maitland sites. Two physicians staff the Atchison County offices: Dr. Niedermeyer in Tarkio owns his own practice, and Dr. Dean is under contract with NHS, although the hospital owns the facility at Rock Port.

NHS offers excellent responsiveness. Patients requesting an appointment for a medical problem can usually see a physician or nurse practitioner on the same day. Physical exams can be scheduled within a week. And within the clinic waiting times for patients with appointments is kept to less than fifteen minutes on average. A walk-in with a current problem may have to wait half an hour before being seen. These standards have been maintained without an apparent loss in productivity.

Each office offers emergency services as well as primary care, due to the considerable distances to area hospitals. Primary care services include: family planning, obstetric care, well child care, adolescent care, well adult care, dental services (off-site), health education, and nutrition assessment. Each office is equipped to perform routine x-rays and basic diagnostic laboratory tests. Special radiology exams are referred to area hospitals and most laboratory tests are sent to an independent commercial laboratory for processing. Pharmacy services are also on-site in Mound City under separate, private and proprietary ownership.

In addition to all the above services, NHS providers offer house calls, extremely important to the elderly portion of the organization's patient population. The same providers also make regular visits to area nursing homes, and since they are paid through cost-based reimbursement, they are without the monthly Medicare visit limitations restricting doctors in private practice. The individual who owns most of the area nursing homes realizes how critical NHS is to the continued viability of his operation; he played a vital role in the initiation of NHS and currently serves as President of the Board of Directors.

Patients requiring hospital or specialty care are cared for or referred to the community hospital in Fairfax, approximately twenty-five miles from Mound City, or to larger facilities and practices in St. Joseph (thirty-five miles), Kansas City (one hundred miles) or Omaha (one hundred miles). NHS physicians maintain admitting and treatment privileges only in Fairfax so the success of NHS is closely linked to the precarious financial future of the very small (fifty bed) rural hospital. Specialists from St. Joseph and especially Omaha maintain regular, monthly, outpatient clinics in Fairfax Community Hospital. Their numbers include: an orthopedist, internist, urologist, cardiologist, gastroenterologist, ENT, ophthalmologist, and a pulmonary medicine specialist.

Utilization and Financial Support:

During calendar year 1988 NHS provided medical care for 6,553 total users. Twenty-eight percent (28%) of those users were over the age of sixty-five. The organization had total expenses for the same period of $1,053,896. Twenty-four percent (24%) or $242,396 of those costs were covered by Medicare revenues, a considerably higher number than the 1988 median (3%) found for all federally-funded community and migrant health centers. Grant funds from the Health Resources and Services Administration (HRSA) accounted for thirty-seven percent (37%) of total costs.

NHS utilization data are only collected for the owned facilities in Holt County. HRSA funds can only be used in these clinics, not in the Atchison offices where Fairfax hospital is responsible for covering any costs uncovered by patient/third party revenues. While Holt County only has an estimated 1,525 citizens over the age of sixty-five (65), NHS served 1851 persons over age sixty-five (65) during 1988. While the organization's total catchment area crosses county boundaries, this statistic provides some insight into the degree of apparent loyalty felt by area residents for NHS.

The medical staff has maintained an excellent level of productivity. During calendar year 1988, NHS physicians averaged 5,813 encounters per full time equivalent for all types of encounters, i.e., hospital, on-site, home and nursing home. During that same period, midlevel provider encounters per full time equivalent averaged 2,751.

In March of 1988 NHS applied for and received certification under Public Law 95-210 as a Rural Health Clinic (RHC). NHS was the first facility in Missouri to receive this designation.

Competition for Elderly Patients:

As indicated above, little competition for primary care services exists in Holt and Atchison counties. St. Joseph, however, is a much larger city only thirty-five minutes of super-highway (I-29) time from Mound City and less than twenty minutes from Oregon, the southernmost NHS site. St. Joseph offers several secondary hospitals, nursing homes and a full range of general and family practitioners, internists, surgeons and subspecialists.

There is little threat of new physicians initiating practice in either Holt or Atchison counties on a non-subsidized basis. When NHS was being reimbursed by Medicare on a fee-for-service basis, the organization was receiving less than $15 per visit, due to the extremely low prevailing fees in the region. New physicians, without access to the RHC or Federally Funded Health Center (FFHC) designations would be forced to collect extremely high balance billings from patients, difficult if not impossible given the economic situation of the area and the presence of NHS. NHS accepts assignment on all Medicare patients, and further offers a sliding fee scale for deductibles and copayments.

There are other key factors which attract the elderly beyond geography and price which are described in the following section.

II. THE NHS GERIATRIC PROGRAM

Because such a large percentage of the patient population is over age 65, geriatric care is a priority for NHS. The health needs of this population have been studied, and specific plans to address those needs have been developed.

Identified Health Needs:

According to statistics collected by the Missouri Department of Health, the major causes of death in Missouri for those over 65 are heart disease, cancer and cerebrovascular disease. These findings appear to hold true for the NHS service area as well; heart disease is the leading cause of hospitalization for NHS patients over 65, and arteriosclerotic heart disease and hypertension are the two most prevalent diagnoses in the service population. The population also faces an increased risk of cancer due to farm related exposures (pesticides, herbicides, etc.).

The health plan developed by NHS for its geriatric population includes:

- blood pressure readings every 6 months for current patients
- outreach blood pressure screenings for groups of elderly in the community
- nutritional counseling for 80% of the elderly with diet related diseases (diabetes, hypertension, etc.)
- yearly colorectal screening using hemocult kits
- yearly mammograms, pelvic exams, and pap tests for females

Special emphasis will be placed in the next two years on improving the extent to which the elderly in the community have been screened for colorectal cancer. It is felt that a large proportion of the over 55 population is at increased risk for cancer because of their age and because of their exposure to chemicals used in farming. Men and women in a rural community also tend not to seek medical care unless they have an acute problem, making outreach all the more necessary.

Description of Services:

NHS does not maintain separate hours or days for geriatric patients. They are incorporated into the general clinic along with all other patients needing care, so that during clinic hours, the waiting room is filled with a mix of patients of all ages and types. Although the operations of the clinic are the same for all types of patients, they are described here because they are an important factor in the high productivity that NHS providers maintain while seeing a large number of elderly patients.

Staffing and Facilities:

At each site, each physician uses three examination/treatment rooms for his patients. The simultaneous use of three rooms ensures a steady flow of patients for the physician. Each doctor also has a clinic assistant (RN, LPN, or trained medical assistant) working with him. The clinic assistant calls the patient from the waiting room (by name), and is responsible for taking the patient's vital signs, recording the chief complaint, and helping the patient undress, if help is needed. After the doctor is finished with the exam, the assistant helps the patient dress and escorts him/her to X-ray or lab, if required. The assistant also reviews the doctor's instructions with the patient, and answers any questions.

The use of three examination rooms and a clinic assistant helps to maintain a smooth and steady flow of patients throughout a clinic session, and is an important reason for the high productivity seen at NHS clinics.

In one clinic, the office assistant/receptionist does double duty as the medical assistant, but in the other three sites, the duties are carried out by different people. In all sites, however, the office and medical staff are members of the community and know most, if not all, of the patients. This gives both a personal feel to the clinics, and provides a sense of continuity that persists even when there has been turnover in the provider staff.

Special Services of Significance to the Elderly:

The following services, either provided by NHS or arranged by the clinic, contribute to the success of the NHS geriatric program.

House Calls. As mentioned above, all of the physicians at NHS make house calls, and are available for phone calls. Although a formal call rotation has been set up, very few patients or doctors avail themselves of it. Patients, therefore, feel that their doctors are very accessible and responsive. This is particularly important to elderly individuals who may have trouble with mobility.

Submission of Insurance Claims. NHS will submit claims for health insurance for its patients free of charge. This is an invaluable service for geriatric patients who may need to submit claims for Medicare, Medicaid, supplemental insurance, and private insurance.

Home Nursing Care. A visiting nurse service provides home nursing and aide services in the area. NHS arranges for these services for their patients when needed.

Nursing Home Services. There are five nursing homes in the area serving NHS patients. Three of these are part of the Tiffany Care Centers chain. These nursing homes provide skilled, intermediate, and residential care. The physicians from NHS follow their patients in the nursing homes.

Swing Beds. The Fairfax Community Hospital has a number of "swing beds" which can be converted from acute care to extended care status as a patient recuperates. This feature is particularly useful for elderly patients who may

have lengthy recovery periods, or who may have no one at home to help them. The swing beds can also help to alleviate any shortage of skilled nursing beds at local nursing homes.

Transportation. Transportation remains a major problem for a small number of the rural elderly. The Division on Aging operates a van (OATS - Older Adults Transportation System) to bring the area elderly to the congregate meal site in town, which is located just down the street from the clinic. No formal linkage exists between the clinic and the senior center where the meal site is located, but some elderly patients may be scheduling appointments in the middle of the day so they can use the bus to get to the meal site and the clinic. Transportation is most often provided by neighbors, friends, or family, and is sometimes provided by clinic staff in their own personal cars. NHS is trying to get funding for a van to reduce this barrier to care for the isolated elderly of the community.

Educational, Screening and Outreach Programs. NHS has been involved in running a number of programs for the elderly. Many of these programs have taken place at the senior center (which is also the congregate meal site), providing easy access to a large number of the community's elderly. Flu shot and blood pressure screening programs, programs on nutrition, weight loss, cholesterol, Alzheimer's disease, and stress management have been run or are planned for the future.

Factors Contributing to Success of Elderly Services:

In addition to the specific services mentioned above, several features of the NHS clinic system contribute to its success in attracting, serving, and retaining elderly patients. The most important of these are discussed below.

Continuity of Care. Of crucial importance to the success of this system is the continuity of care provided to elderly patients by NHS. Most of the physicians working at the clinic have been in practice in the community for over 30 years and know (and are known by) their patients well. The newer recruits are dedicated to providing the same continuity and same accessibility to their patients.

Beyond the obvious benefits that continuity bestows in terms of knowledge of the patient and his problems, continuity also fosters bonding between patient and physicians that is an extremely important component of care of the elderly. It is this bonding to an individual provider that helps to retain patients in the clinic practice.

Continuity also appears to play a crucial role in maintaining provider productivity, especially given the large number of elderly patients being seen at NHS. Because the physicians are already familiar with most of their patients, they are able to focus on the acute problem that has brought the person to the clinic that day. The visit usually takes no longer than it would with a younger patient.

As mentioned above, continuity is also provided by the office and medical assistant staff. The clinic staff know patients by name, and this provides a

sense of personal care and continuity that can bridge the gap that occurs if there is a change in providers.

Managed Care Approach. NHS providers see their patients not only in the clinic, but are able to follow them in the community hospital, nursing home, and at home. The clinic also has links with other service providers in the area, so that NHS can arrange for any social or medical services a patient may need. These capabilities are particularly important for elderly patients who often have complex needs, and may not be able to make complicated arrangements on their own. It also ensures that each patient receives the comprehensive, coordinated care that he/she may need, and that the physician is aware of what is going on with that patient.

Productivity. As mentioned above, the layout and staffing of the clinics helps to maintain a smooth flow of patients during clinic hours, allowing the providers to maintain a high level of productivity even though they are seeing a large number of elderly patients.

Responsiveness to needs of patients. As evidenced by the list of services presented above, NHS is geared toward identifying the needs of the community and providing services to meet those needs. This includes medical and support services, outreach and educational programs, as well as special services such as health insurance claims submission that are not usually considered part of clinic services. In many ways, the clinic and its providers are able to convey a sense of involvement and caring to its patients, and have been rewarded by a rapidly growing patient population.

III. MEDICARE REIMBURSEMENT

Description of Reimbursement Methodology:

NHS is reimbursed from Medicare under cost-based reimbursement for all owned sites: Mound City, Maitland, and Oregon. In March 1988, NHS received certification under Public Law 95-210 as a RHC. Currently, only the Mound City and Maitland sites are classified as RHCs. Oregon does not have a nurse practitioner on site and, therefore, does not meet the provider criteria for a rural health center; services there are reimbursed under FFHC regulations. NHS manages two hospital-owned health centers which are under fee-based reimbursement. The following table displays the multiple Medicare reimbursement methodologies employed by NHS:

Medicare Reimbursement Modes at NHS

Site	Ownership	Reimbursement base	Classification
Mound City	Owned	Cost based	RHC
Maitland	Owned	Cost based	RHC
Oregon	Owned	Cost based	FFHC
Rock Port	Managed	Fee based	Phys. Office
Tarkio	Managed	Fee based	Phys. Office

NHS converted Mound City and Maitland to cost-based reimbursement because it provides a substantially greater reimbursement than fee-based. Prevailing rates for NHS's service area are relatively low because local physicians, treating a relatively poor population, have kept charges depressed. As a result, reimbursement under fee-based reimbursement, using the prevailing charge methodology, results in reimbursement levels below the current cost of providing services. For example, an intermediate visit has a fee-based reimbursement of $13 compared to $37 under cost-based reimbursement.

Rock Port and Tarkio are both incurring losses in part because of the inadequate reimbursement; these losses are currently being subsidized by the owner, Community Hospital.

Rate Determination and Final Settlement:

Annually, NHS files HCFA Form 222 for Mound City and Maitland (RHC) and HCFA Form 242 for Oregon (FFHC) which computes total cost and cost per visit of providing services to Medicare patients. The cost per visit is used as the interim rate for the upcoming fiscal year. A final settlement is made sometime after the close of the fiscal year, usually within the next fiscal year.

The cost reports are completed from NHS's year end trial balance. Costs are classified as direct or overhead, and assigned to the appropriate cost center: a) health centers reimbursed as RHCs and b) other health centers. Overhead costs are allocated between the health centers using a systematic allocation method. Care is taken that the classification and allocation of costs provide maximum reimbursement within the limits of the regulations.

Claims Processing and Patient Accounting:

Medicare claims are sent directly to Aetna, Medicare's fiscal intermediary. Mound City and Maitland (RHC sites) are sent to Aetna's California office and Oregon claims (FFHC sites) are submitted to Aetna's Illinois office.

Aetna processes claims and forwards payment and remittance advice to NHS. Under cost based reimbursement, NHS receives the same reimbursement rate for each visit regardless of actual charges. However, the reimbursement amount identified as "Provider Payment" on the remittance advice is not always the same, for as yet unexplained reasons.

Upon receipt of the remittance advice, NHS posts the Medicare payments (interim rate) and a contractual adjustment to the patients' account. The contractual adjustment is the amount needed to make the balance due from the patient equal to the coinsurance and deductible as shown on the remittance advice. This is the same amount shown on the patient's Explanation of Medicare Benefits (EOMB).

NHS has experienced some difficulty with the different methods used for RHCs and FFHCs for computing coinsurance and the amount applied to deductible. RHCs must base coinsurance upon actual charges while FFHCs must base coinsurance calculations upon the allowable cost-based level, i.e., the interim rate. Aetna requires that health centers including NHS change actual charges to the interim rate before filing all FFHC claims. Therefore, charges for covered services on the EOMB do not mirror the charges found on the encounter form and posted to the patient's account. This has caused confusion to the patients and requires additional accounting on the part of NHS. NHS sends each patient a special "Medicare" statement which shows total "charges" (equal to the amount filed on the claim), the amount owed for the 20% coinsurance and the amount owed for the annual deductible. These amounts match those identified on the EOMB.

NHS also files claims for supplemental policies. Medicaid cross-overs require more time to process now because Medicare and Medicaid no longer have the same fiscal intermediary.

After NHS has received payment from Medicare and all supplemental carriers, they bill the patient for any balance due. Historically, collections have not been a problem. However, if payment is not received from the patient, a collection letter is sent at 90 and 120 days. The collection letter requests payment and offers financial assistance to those patients who qualify for sliding fee. If payment is not received within 121 days, the amount due is written off as bad debt. NHS does not use a collection agency.

General Accounting:

Patient service revenue for Medicare patients is recorded at gross charge and reduced for any contractual adjustment and bad debt. Contractual adjustments reflected on the statement of revenue and expenses are equal to adjustments posted from the remittance advices plus/minus any final settlement. Bad debt is equal to actual nonpayment of Medicare coinsurance and deductibles due from the patients.

ALBANY AREA PRIMARY HEALTH CARE, INC.

ALBANY, GEORGIA

I. GENERAL PROJECT DESCRIPTION

Background:

Albany Area Primary Health Care, Inc. (AAPHC), located in the southwest quadrant of Georgia, is a non-profit organization established in 1979 to provide health services for people in Baker, Dougherty and Lee counties. The first grant was written by Albany State College to initiate health services in the rural community of Leesburg (Lee County). Health centers were subsequently developed in Albany (Dougherty County), a city of approximately 75,000 people, and a second rural town, Newton (Baker County). All three counties have been designated as medically underserved and health manpower shortage areas. Their combined population is approximately 116,000.

AAPHC operates in a fourteen county planning area that has the highest poverty and unemployment statistics in Georgia, outside of Atlanta. Atlanta, the tertiary referral city for AAPHC, is roughly a three and a half hour drive north from Albany. Approximately twenty-one percent (21%) of Dougherty County residents live below one hundred percent (100%) of the federal poverty level, as well as seventeen percent (17%) of Lee County and twenty-seven percent (27%) of Baker County residents. These rates are substantially above the U.S. average of twelve percent (12%). Thirty-nine percent (39%) of AAPHC's users have incomes below one hundred percent (100%) of poverty.

AAPHC's service area does not contain an especially large population, proportionately, of elderly residents. Four percent (4%) of women in the area and six percent (6%) of men are sixty-five years of age or older. This compares with nine percent (9%) of men and thirteen percent (13%) of women nationally.

Services:

The three health center offices operate with day time hours that vary slightly from site to site: 8:30am to 5:30pm in Albany, 7:00am to 4:00pm in Newton, and 8:00am to 5:00pm in Leesburg. In Leesburg, extended hours, till 7:30pm, are offered two days a week. None of the sites is open on Saturday. Twenty-one providers staff these clinics including eleven physicians, one dentist, six mid-level practitioners and three masters level professionals (in mental health, social work and dietary). All three facilities are modern, attractive structures, which could not be visually differentiated from private physicians' offices. This feature is by design. The medical director, who completed his medicine residency at a large urban tertiary care center, has been determined to avoid the negative "clinic" image usually associated with services for low income persons.

Unlike most medium-sized community and migrant health centers (C/MHCs), AAPHC has no family practice physicians. Seven of the physicians are internists and the other four are pediatricians. The medical director claims that recruiting a family practitioner proved extremely difficult in the early years. Partially in response to that problem, the organization has since recruited internists to meet adult care needs and pediatricians for children, relying on physicians' assistants to fill in any care requirements left unaddressed. Another key difference from most health centers is that AAPHC does not provide prenatal care or hospital deliveries. Prenatal care for individuals not seen by private physicians is provided by the local health department, and deliveries at local hospitals are limited to board certified or eligible OB/GYNs. Even if AAPHC had family practitioners they could not deliver.

Each of the three AAPHC centers offers primary preventive and curative medical care for both adults and children. In addition, one of the rural sites provides dental services, and all three have basic laboratory services on the premises. These basic services are augmented by an on-staff social worker and health education specialist. Two providers specialize in care of the elderly. One of the internists has maintained a on-going interest in aging and last year became board certified in geriatrics. His interests and the large number of geriatric patients attracted to AAPHC has led to the recent hiring of a physician assistant who specializes in geriatrics.

AAPHC coordinates services closely with the health department. Health center providers staff the Department's child and infant clinics and the alcohol detox unit. AAPHC physicians also provide the medical direction for EMS services in Lee and Baker counties, back up health department nurses writing prescriptions, take HIV positive patients on referral, staff family planning clinics, and serve on the Board of Health for both Baker and Dougherty counties.

Utilization and Financial Support:

During calendar year 1988 AAPHC provided care for 11,765 total medical users. Of these users one thousand seven hundred forty (1,740) or approximately fifteen percent (15%) of the total were over the age of sixty-five. The organization had total expenses for the same period of $2,500,593. Twenty percent (20%) of those costs were covered by Medicare revenues, a considerably higher number than the 1988 median (3%) found for all HRSA-funded C/MHCs. Total Medicare revenue received for the period amounted to nearly $500,000. HRSA grant funds accounted for approximately thirty-one percent (31%) of total costs.

The proportion of elderly users at AAPHC exceeds the community proportion of persons aged sixty-five or older, an unusual statistic for C/MHCs. AAPHC's older patient population has led to greater than usual health center hospital activity; approximately thirty percent (30%) of total encounters take place in the hospital. This large hospital practice is also at least partially due to the many internal medicine hospital consults requested of AAPHC internists by non-AAPHC physicians in the community.

The large number of elderly have not apparently reduced the efficiency of the practice. During 1988 the health center averaged 5,885 encounters per full time equivalent physician for all types of encounters, i.e. hospital, on-site, home and nursing home. During that same period the mid-level practitioners averaged 3,052 encounters per full time equivalent. The major current barrier to greater productivity is limited space. The number of users and encounters has been steadily increasing, outstripping available space. The original plan of one office and two exam rooms per provider, key to efficient internal medicine practices, has not been maintained. The organization is down to two rooms per provider, and even that ratio will slip unless additional space can be developed.

Competition for Elderly Patients:

AAPHC currently has both the largest internal medicine and the largest pediatric group in the Albany area. The health center has seven of the twenty-one internists practicing in the community, and four of the twelve pediatricians. The medical staff is relatively stable and unusually well integrated into the mainstream medical community. Only four of the eleven physicians have National Health Service Corps obligations. The staff geriatrician, who has been with AAPHC for ten years, is currently president of the local community hospital medical staff, and other health center physicians serve as chairpersons of important hospital committees. These ties to the non-C/MHC medical community are reflected in the number of consults requested by doctors outside the health centers.

There is some limited competition for Medicare-covered patients in the area, but none of the other providers offers the full range of financial and continuity of care advantages that AAPHC does. AAPHC lets its advantages speak for themselves. The provider staff professed to reject any conscious "business" strategy of self-promotion, and there is no paid advertising. One major advantage is that the health center takes assignment on all Medicare patients, relieving the elderly of claims processing complexities as well as excess charges. Patient costs are reduced still further when the AAPHC sliding fee scale is applied to deductibles and copayments. Another important cost advantage is the reduced price drug program, described more fully in the next section. Only AAPHC patients are eligible to purchase pharmaceutical products at radically reduced cost.

The continuity of care advantages stem largely from the commitment of the staff geriatrician. When he started in AAPHC practice, he customarily turned his nursing home patients over to those institutions' house doctors. He grew to reject that practice, and currently, with the assistance of a geriatric physician assistant, is able to follow the care of elderly regardless of site. Either he or the physician assistant, who has a masters degree in gerontology and was most recently on the faculty at the University of Texas, follow up on patients at home, in nursing homes, hospitals, and personal care homes.

II. THE AAPHC GERIATRIC PROGRAM

The following are the most common diagnoses for the over sixty-five patient population at AAPHC:

- o High blood pressure
- o Diabetes mellitus
- o Degenerative joint disease (arthritis, etc.)
- o Dementia
- o Urinary tract infection

The staff geriatrician and geriatric physician assistant have established a comprehensive geriatric assessment tool that is completed for patients with an identified range of needs. They are identified through the use of a "jog" sheet which can be completed by any of the staff internists. The organization estimates that over nine hundred of AAPHC's elderly patients are in need of the comprehensive assessment; approximately 300 should be completed by June of 1990. Assessments completed to date indicate that fifty percent (50%) of those reviewed are poorly functioning elderly in inadequate home environments. AAPHC is the only medical group performing comprehensive geriatric assessments in all of Southwest Georgia.

Current clinical goals for the AAPHC staff include cancer screening for colon and breast, especially for women fifty years of age and older. All health center internists have been trained in the use of a AAPHC-purchased flexible sigmoidoscope, using a detailed protocol governing its use. Other health center-owned equipment of special relevance to the elderly include an EKG machine and a spirometer for assessing pulmonary function.

Many elderly are especially attracted by AAPHC's reduced cost drug program which is available to patients of all ages. The health center, which does not have its own internal pharmacy, contracts with ten independent pharmacies located throughout the service area. Patients take AAPHC prescriptions to participating pharmacies and are required to pay $5.00 for each prescription plus any costs in excess of $60.00 per prescription. For example, if a prescription costs $80.00 the patient will pay $5.00 plus the $20.00 cost above the $60.00 maximum. All refills require a return visit to the health center. AAPHC is billed for the difference between the amount paid by the patient and the actual cost. An annual drug subsidy budget, currently $65,000, is strictly adhered to. When the allotment has been depleted the subsidy is halted until the next fiscal period. Last year the pharmacy subsidy lasted for ten months.

The pharmacy subsidy program is not the only drug cost savings offered by AAPHC. Health center medical staff successfully lobbied a major drug manufacturer for free coupons for the popular potassium replacement Calan. Over 1,200 coupons each worth $40.00 were passed out during the past year, for a total value of $48,000. A third means of assistance is the distribution of free samples, also provided by pharmaceutical representatives.

AAPHC staff during 1989 provided over seven hundred nursing home visits and over two hundred visits to personal care homes. Personal care homes, situations where usually untrained individuals care for up to seven elderly in a private home, are often rampant with problems. Unlike nursing homes or even homes for the aged they are relatively unregulated. AAPHC staff, along with the local council on aging and the welfare agency, have taken on the responsibility for monitoring these care sites. AAPHC patients in personal care homes are visited by the geriatric nurse practitioner at least once a month. In addition to observation and assessment, homemaker and/or housekeeper and other support services are arranged through the Council on Aging.

Health center staff work closely with the Council on Aging, both in terms of advocacy and coordinating services. Six years ago the geriatrician, for example, initiated with the Council an Alzheimers Support Group for families of Alzheimers patients. This is a local chapter of the national organization.

AAPHC staff have also taken a geriatric leadership role in the community hospital; they have recently developed a geriatric division. Division membership includes one internal medicine physician in addition to the AAPHC geriatrician, two family practitioners who serve as nursing home medical directors, a nutritionist and a social worker. The hospital has also recently hired a RN geriatric specialist. A distant goal is the development of a geriatric unit where special programs, such as fall prevention and family support, could be offered.

The AAPHC geriatrician has also initiated a geriatric clinical conference held weekly at the community hospital. This session, held in the hospital conference room, reviews the medical needs and care of an individual patient. Participants beyond the AAPHC geriatrician and geriatric physician assistant include: the hospital RN geriatric specialist, a dietician, a rehabilitation specialist, a RN discharge planner, a pharmacist and physician assistant (PA) students.

Adults and children are separated as soon as they enter the main AAPHC facility in Albany. There are separate waiting rooms, and the adult provider offices and exam rooms are located in different areas of the building from pediatrics.

Features of Significance to the Elderly:

AAPHC administrative and clinical staff listed the following features of special significance to the elderly, to include those discussed above:

Comprehensive Care. Care is provided wherever necessary, at the health centers, personal care homes, private homes, nursing homes, and hospitals.

Medicare Assignment. Accepting Medicare assignment frees the elderly from concerns about claims processing paperwork, and from charges above those allowed by Medicare. A further financial advantage for patients results from the application of the AAPHC sliding fee scale to co-insurance and deductibles.

Reduced Drug Costs. The elderly, with high annual drug charges, reduce their out-of-pocket expenses through the AAPHC pharmacy subsidy program, drug company coupons, and free samples.

Provider Continuity. AAPHC has made provider retention a major objective, and has been largely successful. This is important to the elderly, who become bonded to individual care givers, not institutions.

Provider Expertise and Visibility. AAPHC physicians are among the leaders in the medical community, most notably in geriatrics. They are at the forefront of mainstream medical care.

Community Networking. AAPHC providers have initiated and maintained important linkages with key community groups, including the hospital and the Council on Aging, for advocacy as well as coordination of care purposed.

Attractiveness of Facilities and Staff. The modern office buildings and equipment, as well as the professional appearance of the staff, are major attractions to the elderly who would reject the appearance of second class care.

III. MEDICARE REIMBURSEMENT

AAPHC is reimbursed through two modes for Medicare-covered services, as displayed below:

Medicare Reimbursement Modes at AAPHC

Site	Reimbursement Mode	Classification
Leesburg	Cost-Based	Rural Health Clinic
Newton	Cost-Based	Rural Health Clinic
Albany	Fee-For-Service	Physician's Office

The Newton and Leesburg sites qualify under Public Law 95-210 as rural health clinics, and are therefore eligible for cost-based reimbursement. The Albany site does not qualify as a rural site, and the health center administration was not previously aware that the organization could have qualified the Albany office for cost-based Medicare reimbursement under the Federally-Funded Health Center regulations. Albany, therefore, has been reimbursed for Medicare services on a fee-for-service basis.

Fee-For-Service: The Process

Albany fees are determined on a competitive basis. The organization is determined to keep fees equal to or, preferably, slightly below those of private physicians. Currently AAPHC fees are very close to Medicare allowable

charges for most items, as determined by the organization's historical (customary) fees and the (prevailing) fees charges by physicians in the area.

AAPHC tries to collect any deductible ($75 annually) and co-insurance (20%) from patients as they exit and confront the cashier when registering for follow-up appointments. If too much money is collected then the patient may be sent a check after the health center has been notified by the intermediary. Most elderly patients actually prefer to maintain a credit balance with AAPHC rather than receive the money due to them. The cash collection policy at the time of service is applied to all AAPHC persons. In fact, full cash payment is requested at the desk from all patients except Medicare and Medicaid-covered patients, who only pay deductibles and co-insurance portions. AAPHC charges a minimum fee of $5.00 and is currently considering an increase to perhaps twice that amount.

Encounter forms are collected daily and entered on "MedCare" software, regardless of the third party payer involved. Medicare claims are transmitted electronically as soon as they are batched for the day. They can be sent to AAPHC's new fiscal intermediary, Aetna, at any time between 8:30am and 5:00pm. While Aetna could pay all clean claims immediately, federal legislation designed to improve the government's cash position requires a two week delay. Aetna does handle all Medicare/Medicaid "cross-overs" (where Medicaid acts as a supplemental policy) automatically. Other "Medigap" supplemental insurers must be billed directly by AAPHC.

Patients are billed for outstanding balances monthly. After ninety days have passed without payment they are notified in a letter that their account will be referred to a collection agency; at the same time they are also encouraged to request sliding fee scale approval. The collection agency uses a "soft" approach which does not threaten credit ratings, and has yet to demonstrate its effectiveness.

Rural Health Clinic Reimbursement: The Process

AAPHC follows a very similar process for rural health reimbursement at the outlying clinics, nearly identical for patient billing. (The co-insurance percentage is still based upon clinic charges, not the allowable cost per visit). There are differences, however.

One difference is the requirement for annual cost reports to determine full allowable costs and the cost per visit reimbursement level. This is not an easy process, especially when done to maximize reimbursement. Medicare, for example, will pay for bad debt, as long as the provider can prove that an effort was made to collect from the patient. Documentation must be maintained.

The ceiling for rural health reimbursement has risen considerably. Over the past two years Newton has increased its rate per visit from $32.00 to $45.75, while Leesburg has increased from $32.10 to $47.25. The fact that these rates are for Medicaid as well as Medicare only increases their value. AAPHC looks forward to evaluating cost-based reimbursement through the 1989 Omnibus Budget Reconciliation Act (OBRA) legislation for the Albany site.

ALTON PARK/DODSON AVENUE COMMUNITY HEALTH CENTERS

CHATTANOOGA, TENNESSEE

I. GENERAL PROJECT DESCRIPTION

Background:

The Alton Park and Dodson Avenue Community Health Centers (APDACHC) are located in the inner city of Chattanooga, Tennessee, just north of the Georgia border. The Alton Park site was initially established by the Erlanger Hospital in 1968, with financial support provided by the federal Office of Economic Opportunity (OEO). Services and administrative offices are located in a former community school building which houses other community services as well. Eight years later the Dodson Avenue center was founded eight miles to the north.

Both health centers operate under a co-applicant agreement approved by the Health Resources and Services Administration (HRSA) with the Hospital Authority Board of the Erlanger Medical Center (EMC), a 750-bed tertiary care center with a national reputation for teaching, research and patient care. The health centers operate under the same personnel policies, benefit plans and institutional liability as the hospital. APDACHC, however, has an independent policy-making Board and the health center executive director is only answerable to that Board. The health centers benefit from the Erlanger connection: from the hospital's buying power, personnel system, liability insurance, credibility in the community, and specialty referral channels. Erlanger residents and attending staff also admit and follow all APDACHC indigent patients in need of hospitalization; patients with third party coverage, in contrast, are admitted and treated by health center physicians.

Alton Park's immediate neighborhood is characterized by demographic extremes, with proportionately many more elderly and youth than would be expected. This is due to the nearby presence of four of the largest public housing projects in the city, populated primarily by single mothers and their children, and approximately ten high rise public housing residences for the elderly.

While the Dodson Avenue site does not have the extreme concentrations of elderly and children in nearby neighborhoods its considerably larger service area does contain more of both groups. Also, the majority of EMC referrals are made to the Dodson Avenue location due to proximity. These are generally patients who initially appeared in EMC's emergency room, and who are indigent with no third party coverage. This is the major advantage to EMC of the APDACHC connection, a significant reduction in free care and bad debt obligations.

The majority of patients at both sites is black. The Alton Park area, however, includes a large number of poor and working class persons, and

therefore often uninsured whites. In addition, the center is only one half mile north of the Georgia border; the adjacent Georgia counties of Catoosa and Walker are suffering from increasing unemployment due tc the closing of numerous textile mills. No HRSA-funded projects serve the area. These poor whites, as well as blacks, also come to Alton Park. As a result the ratio of users by race at the Alton Park site is approximately sixty percent (60%) black and forty percent (40%) white.

Twenty-five percent (25%) of persons in the total APDACHC service area live with incomes below one hundred percent (100%) of the national poverty level, and forty-five percent are below two hundred percent (200%) of this standard. In terms of age, the service area fairly well mirrors national averages. Approximately ten percent (10%) of men and fifteen percent (15%) of women in the APDACHC area are over the age of sixty-four. This compares closely to national averages: nine percent (9%) of men and thirteen percent (13%) of women.

Services:

Both Alton Park and Dodson Avenue sites are open for service from 8 am to 7 pm on Monday, 8 am to 5 pm Tuesday through Thursday, and 8 am to 3 pm on Friday. The services offered have remained relatively constant over the years, except for family planning activities which have been scaled back radically following budget cuts. APDACHC provides general adult, pediatric and adolescent medicine, obstetrics and gynecology, family planning, special hypertension and blood pressure programs, dental services, WIC program services, diabetes counseling, home health, transportation and in-house pharmacy, laboratory and radiology services. The home health services are provided by a APDACHC-owned agency which is based in the Dodson Avenue facility.

Health center physicians provide twenty-four hour coverage for medical problems. All six of APDACHC's non-National Health Service Corps (NHSC) physicians are independent contractors, although not all have outside practices. They receive an annually fixed level of cash compensation; each individual doctor or group is responsible for securing fringe benefits. There are currently four NHSC placements. Of the ten physicians (8.2 full-time equivalents), two are obstetrician/gynecologists, one is a family practitioner, five are internists and two are pediatricians. All of the staff are either board certified or eligible, with most certified. There are three full-time dentists.

APDACHC physicians do not make house calls.

Utilization and Financial Support:

During calendar year 1988, APDACHC provided services to 11,871 medical users and 3,331 dental users. Thirteen percent (13%) of those medical users were over the age of sixty-five, a slightly higher proportion of elderly than found in the service area's general population. The organization had total expenses for the same period of $3,917,019. Fourteen percent (14%) or $568,618 of the total costs were covered by Medicare, a considerably higher percentage

than the 1988 median (3%) found for all HRSA-funded community and migrant health centers.

During calendar year 1988 the health center averaged 4,992 encounters per FTE physician for all types of encounters, including hospital and other locations as well as on site at APDACHC. Space is a limiting factor. The Dodson Avenue site handles approximately the same number of encounters as Alton Park within thirty-five percent (35%) of the space, 7,000 versus 20,000 square feet. There are, usually, two exam rooms per physicians. Each doctor does have a LPN or a medical assistant regularly assigned to him/her.

APDACHC tracking of ancillary procedures by payment source reveals the following about Medicare patients when compared to other payment groups:

IN-HOUSE ANCILLARY SERVICE UTILIZATION BY PAYMENT SOURCE

	PAYMENT SOURCE			
Service	Medicare	Medicaid	Private Insurance	Self Pay Sliding Scale
Laboratory	6,502	14,173	5,569	21,163
X-ray	510	388	225	714
EKG	364	106	83	253
Other	5,294	5,474	234	39,321

RATIO OF PROCEDURES TO PHYSICIAN ENCOUNTERS

Service	Medicare	Medicaid	Private Insurance	Self Pay Sliding Scale
Laboratory	1.11	1.30	1.54	1.56
X-ray	0.09	0.04	0.06	0.05
EKG	0.06	0.01	0.02	0.02
Other	0.90	0.50	0.06	2.90

The table indicates that Medicare patients required fewer laboratory tests per encounter than Medicaid, private insurance and self pay patients, but more x-rays and EKGs.

There were over sixteen hundred (1600) hospital visits made to Medicare-covered patients by APDACHC physicians during the last fiscal year ending June 30, 1989. Of the 7,624 total home health encounters provided by APDACHC's home health agency, 5,653 or seventy-four percent (74%) were reimbursed by Medicare. The Medicare-funded home health encounters were provided by the following staff:

MEDICARE-REIMBURSED HOME HEALTH VISITS

July 1, 1988 - June 30, 1989

Type of Encounters	Number Provided
R.N. Encounters	2,413
Family Health Worker Visits	1,541
Physical Therapy Visits	1,658
Speech Therapy Visits	26
Social Work Visits	15
Total Encounters.....	5,653

During this fiscal period (FY88/89) the home health agency earned $335,277 Medicare dollars, approximately eighty percent (80%) of the total home health agency revenues of $429,464.

Competition for Elderly Patients:

Area Providers

There are approximately one hundred thirty (130) primary care physicians in Hamilton County of which four (4) are located in Alton Park's immediate service area and thirty-nine (39) are located in Dodson Avenue's service area. Currently, there are no primary care physicians with a specialty in geriatrics. Erlanger Medical Center (EMC) had started a geriatric program but discontinued it because of financial constraints.

Less than fifty percent (50%) of area physicians accept assignment for Medicare and the number is declining as Medicare continues to cut reimbursement for services. Moreover, none of the four physicians located in Alton Park's service area take assignment for Medicare and seventeen (17) of thirty-nine (39), or forty-three percent (43%) of the physician's in Dodson Avenue's service area take assignment.

Market Demand for Services

Overall, the demand for visits within the service area exceeds the supply. The most recent analysis estimated total demand for the service area to be 227,504 visits compared to an estimated supply of 189,010 visits. There is a general feeling that the shortage of supply is even greater for the service area population over age sixty-five because of the few physicians accepting Medicare assignment.

Alton Park established itself as a provider with the elderly community early on. A key fact is that the opening of the Alton Park center occurred

only two years after the completion of two major nearby elderly housing projects. Health center staff also conducted extensive door-to-door outreach to the community including the elderly housing projects in the early days of Alton Park when funds were available for that purpose. Although the outreach efforts have been discontinued, the health center continues to attract elderly patients from these housing projects. The health centers serve approximately seventeen percent (17%) of the over age sixty-five population within the combined service area. This compares with an overall market penetration rate of twenty percent (20%) for Alton Park and approximately ten percent (10%) for Dodson.

II. THE APDACHC GERIATRIC PROGRAM

The APDACHC preventive health plan calls for an annual physical exam for all persons over the age of sixty-one, with an updated and comprehensive history completed every five years. The health center plan specifies the following procedures and frequencies:

GERIATRIC PREVENTIVE HEALTH PLAN

Procedure	Frequency
Weight measured	Each visit
Blood pressure taken	Each visit
Visual acuity (Tonometry)	Every 2 years
Hearing assessed	Every 2 years
Dental screening	Every 2 years
Cancer screening (Pap smear)	Annually
Urine analysis	Annually
Mammogram	Annually
Glucose	Annually
STD	Annually
Hearing screening	Annually
Cholesterol	Annually
HCT	Every 4 years
EKG	Annually
PPD	Every 2 years

The same plan calls for the following patient education activities: a) self--examination of breast, testicles, neck, skin and mouth; b) self-assessment for signs of cancer and diabetes, c) diabetic counseling, and d) nutrition counseling regarding elevated cholesterol as well as hypertension and hyperglycemia.

The geriatric clinical objective for the current year targets enhanced early detection of asymptomatic and active TB and seroconversion of PPD's. The clinical staff has agreed upon the following action steps:

A. With each complete annual examination, a 5TU PPD is placed or a chest x-ray is given if the patient has a history of positive PPD.

B. Each PPD is read forty-eight hours following placement. If a question of anergy exists, an entire anergy panel will be placed in addition to the 5TU PPD.

C. If the PPD or chest x-ray is remarkable, current guidelines for therapy/management will be followed as set by the Center for Disease Control.

A log has been created for TB screening and follow-up in addition to the documentation included on each individual's health center chart.

An on-going service of special interest to the elderly is an in-house low cost pharmacy program. Patients pay a portion of the actual drug cost, with a ceiling per prescription of $20.00. The current arrangement is as follows:

PHARMACY FEE SCHEDULE

Patient Co-Payment	Cost to Health Center
$4.00	Less than $5.00
$7.00	$5.00 to $9.99
$15.00	$10.00 to $19.99
$20.00	$20.00 and above

Many drugs, distributed to APDACHC as samples, are also made available to elderly patients at no cost, further reducing their out-of-pocket expenses.

Another activity of special interest for the elderly is a hypertension program supported in part by special state funding. This program provides for once-a-week educational programs, screening, and follow-up for all persons within the service area.

The elderly also are heavy users, along with young mothers, of the APDACHC transportation system, which is currently operating two vans. The system runs on appointment. Delays waiting for the van and for service within the health centers add up to considerable time away from home. An elderly person with a 11:00am clinic appointment is likely to be picked up at 10:00am and returned home at 4:00pm.

A final program with great value to the elderly is the dental service. The APDACHC program offers the following services:

APDACHC IN-HOUSE DENTAL SERVICES

Services	Procedures
Diagnostic	Examination X-Rays
Preventative	Prophylaxis, Fluoride Tx Home Care Instructions Periodontal Scaling and Surgery
Restorative	Amalgam Composites Chrome Crowns
Endodontics	Pulpotomys, Root Canal Root Canal Fillings
Surgical	Routine Extractions Soft Tissue Impactions
Prosthetics	Full Dentures

These services, provided through the sliding fee scale which qualifies most elderly participants in the "0" payment category, results in major cost savings. The full lab fees must be paid by the patient for prosthetics. During fiscal year 1988/89 a total of nine thousand seven hundred (9,700) dental encounters were provided.

Features of Significance to the Elderly:

APDACHC administrative and clinical staff listed the following features of special significance to the elderly, to include those discussed above:

Transportation. For the elderly, apparently the financial cost savings from free transportation outweigh the time costs involved in using APDACHC's centrally dispatched van system.

Dental Program. The elderly are attracted by the low cost of the health center dental program; these are services uncovered by Medicare and most Medicare supplemental policies. This attraction then leads the same people to the medical services.

Sliding Fee Scale. Most elderly are qualified out of Medicare deductible and co-payment requirements by virtue of their low income status.

Committed Physician. One family practitioner in particular has been with the health center since its inception (twenty years). While her practice is not limited to geriatrics she is known to the elderly as one who is extremely sympathetic to their needs. She has been known, on several occasions, to loan her own personal funds to elderly patients to assist in prescription purchases.

Stable Support Staff. Key support staff, including nurses and the receptionists who are first to greet patients, have been with APDACHC for many years. They know patients by name, understand their situations, and are able to provide service that feels very personal to their elderly patients.

Claims Assistance. Many of APDACHC's elderly patients are illiterate. Taking assignment from Medicare does more than assist financially. A fiscal support person, who also has been with the organization since its founding, processes the paperwork and helps individuals understand the notices that they receive at home.

Erlanger Connection. The elderly are attracted by the fact that APDACHC is an Erlanger Medical Center institution. They know that the health center physicians are on the Erlanger staff, and that they will be hospitalized in a first rate institution.

Home Health Agency. Referrals go both ways in this arrangement. Patients become APDACHC patients after receiving home care through the health center's agency, and the home health agency keeps home care "in the family" for on-going health center patients.

III. MEDICARE REIMBURSEMENT

Medicare visits make up 13% of total visits for both sites. Most (65%) of the health centers' Medicare patients have Medicaid or private supplemental coverage. Another 25% are indigent patients and pay only the minimum fee for clinical visits and pharmaceutics. The remaining 10% pay some percentage of the balance due for deductibles, coinsurance, non-covered services, i.e, dental and pharmaceutics.

Reimbursement Methodology:

Alton Park and Dodson Avenue health centers are reimbursed for Medicare services through Erlanger Hospital's Medicare cost report. Originally, this method provided much better reimbursement to the health centers. The health centers were shown on the hospital's cost report as a separate cost center and allocated a percentage of hospital overhead costs. As a result, the actual health center cost of providing health center services was significantly less than total (hospital plus APDACHC) cost reported on the cost report and, ultimately, the amount reimbursed to the health centers. However, this is no longer the case. The hospital changed its indirect cost allocation method and allocates only those costs specific to operating the health centers. These include a small percentage of management salaries and the cost of providing payroll services. Because of these changes and the corresponding decline in Medicare settlements with the hospital, the health center's management is

currently investigating the impact of transferring to independent cost reimbursement through federally funded health center (FFHC) regulations.

At the end of each fiscal year, the hospital completes the Medicare cost report and reconciles the amount due to (from) the health centers for Medicare services. The amount due to (from) the health center is essentially equal to costs of providing Medicare services, including bad debt, less Medicare charges net of deductibles and co-payments. The costs are actual direct costs incurred by the health center for Medicare visits plus a small allocation of hospital overhead as discussed above. Charges are actual Medicare charges for the year. Deductibles and coinsurance are computed as a percentage of charges; the percentage is based upon historical data.

As of the end of fiscal year 1988, the health centers had almost $700,000 in receivables from the hospital for interim Medicare settlements. The amount will be paid to the health centers upon the hospital's final settlement with Medicare.

Medicare Claims Processing:

Medicare claims are processed through four fiscal intermediaries based upon the type of service and/or benefits as follows:

Equicore -	Professional component equal to 63% of physician charges, i.e. office visit and procedures.
BC/BS of Chattanooga	Facility component equal to 37% of physician charges and all ancillary services, i.e. lab and x-ray.
Travelers	Professional component equal to 63% of physician charges for those patients under Railroad Retirement benefits.
BC/BS of S. Carolina	Home health charges

Split billing for professional and facility components is used because the health centers are owned by the hospital and are reimbursed through the hospital's cost report.

The health center receives an interim reimbursement from the various fiscal intermediaries for Medicare claims. Reimbursement for professional services is based upon a relative value scale developed by Equicore. The facility component is reimbursed based upon an approved rate which is currently 78% of the overhead charge. Lab and x-ray services are reimbursed according to a fee schedule. Final reimbursement is through the hospital's cost report as discussed above.

☆U.S. GOVERNMENT PRINTING OFFICE: 1991.288.23021402

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Bureau of Health Care Delivery and Assistance

DHHS Publication No. HRS-D-PC 91-2